Healthy Toronto 2000

Healthy Toronto 2000 Subcommittee, Board of Health, City of Toronto, September, 1988

The Board of Health
for the City of Toronto Health Unit

90-05012/

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A LETTER FROM THE CHAIRMAN

At last, here is the Report of the Healthy Toronto 2000 Sub-Committee. The Report constitutes a blueprint for the Department of Public Health and the City of Toronto to the end of the century. We believe that our Report lays out a desirable and feasible program that will help make Toronto the healthiest city possible.

We have identified the major challenges to Toronto's health and addressed the question "What needs to be done to make Toronto a healthy city?".

We have consulted widely with the community and with the Department staff in identifying the challenges and our response to those challenges. Our thanks go to all who helped us by participating in the vision workshops and responding to our discussion paper.

As our terms of reference also required, we have reviewed the implementation of Public Health in the 1980's and are satisfied with the progress made. We do not believe that any major changes are necessary to the Department's present structure. We recommend, however, that the boundaries of the Health Areas and the composition and function of the Community Advisory Boards be reviewed by the new Board of Health and City Council in light of the new City ward boundaries and Council structure, and with a view to achieving the objectives of the Healthy City Strategy.

We believe that our Report, the proposed City-wide Healthy City Initiative and the proposed Department Healthy City Strategy will establish bold new directions and exciting new standards for public health in Toronto and elsewhere in the next decade.

Sincerely,

Councillor Jack Layton
Chair, Healthy Toronto 2000 Subcommittee

Membership: Healthy Toronto 2000 Subcommittee

Councillor Jack Layton, Subcommittee Chair and Chair, Board of Health;

Mr. Sydney Baxter, Business Manager, Downtown Health Area;

Ms. Donna Biesenthal, Manager, Personal Health Services, Eastern Health Area (to September 1986);

Mr. John DeMarco, Member, Board of Health (to December, 1986);

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Dr. Richard Fralick, Associate Medical Officer of Health, Northern Health Area (to September 1987);

Ms. Ilda Furtado, Provincial Representative on the Board of Health (from December 1987);

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Dr. Trevor Hancock, Associate Medical Officer of Health, Northern Health Area (to September 1986);

Ms. Magda Lewis, Member, Northern Health Area Community Advisory Board and Board of Health (to December 1986);

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Department of Public Health Staff Support and Consultation:

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"Many would be surprised to learn that the greatest contribution to the health of the nation over the past 150 years was made, not by doctors and hospitals, but by local government."

Dr. Jessie Parfit

The Health of a City: Oxford 1770 to 1974

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The Report in Brief

Ten years ago, the role, function and structure of the Department of Public Health was radically altered by the report, *Public Health in the 1980's*.

Today, a decade later, most of the recommendations in that report have been implemented, and the Department is far more active in a wider range of public health issues. This has given rise to a new realization - that much that will promote or enhance the health of the people of Toronto lies "beyond health care" - as the Board of Health's centennial conference put it in 1984 - and beyond public health itself. It was this thinking that led to the "Healthy Toronto 2000" workshop that accompanied the "Beyond Health Care Conference" that year - a workshop that proved to be the inspiration behind the World Health Organization's "Healthy Cities" project and the Canadian "Healthy Communities" project and of course, this Report.

This Report is not so much a paradigm shift - as was *Public Health in the 1980's* - as an evolution and refinement of our thinking since then. It recognizes that the process of improving the health of the community is slow and complex; that the profound changes in social values and attitudes that are necessary are the result of a long-term commitment to a multi-faceted and broad-based process of social change; and that many of the challenges to health that we face are interrelated and will require a holistic approach for their resolution. Further, it addresses as much the City as a whole, and City government, as the Department of Public Health. To make Toronto the healthiest city possible, we must ensure that health is a principal concern on everyone's agenda and that the health impacts of our decisions are recognized and taken into account. This is the central message of Healthy Toronto 2000.

Some Fundamental Concepts and Values

We see health as a resource for everyday life. People wish to be healthy in order to lead rich and fulfilling lives, and to attain their maximum potential. In this context, health is more than just physical health - we have to pay much more attention to mental and social well-being.

We recognize that the level of health of our community is a reflection of the quality of our community and that a high level of health for all in our community must be our aspiration. Therefore the basic prerequisites for health must be available to everyone.

Health is a complex phenomenon involving physical, mental and social well-being and is determined by many factors. We therefore need a sophisticated understanding of health, one which illuminates the complex interactions and the holistic nature of the determinants of health and can guide us in our actions.

We have come to recognize certain fundamental public health values. These include:

- Promotion of health and prevention of disease are better than cure.
- Social interventions to enhance the common health of the community are appropriate and may take precedence over individual concerns.
- Inequalities in health must be reduced and their roots in social inequities must be addressed.
- We must treat our natural ecosystem with respect, both for our own benefit and for the benefit of future generations and we must provide for them a clean, green, quiet, healthy and sustainable environment.
- Our community must be human-centred and human scale, a caring, sharing, cooperative and supportive community that places people above material things.
- Each individual in society needs a meaningful role and the ability and the opportunity to participate actively in the community and in decisions affecting their health.

A Healthy City Initiative

The recognition of the breadth of our concerns with health, compared to the somewhat narrower responsibility of the Department of Public Health, leads us to an inevitable conclusion. City government as a whole and the community-at-large of the City must become involved in any effort to make Toronto the healthiest city possible. This calls for a broad, multisectoral and community-based initiative which the Board of Health and the Department of Public Health can help to initiate but cannot implement alone. Within this broad initiative, the Department must develop its own healthy city strategy.

Health Goals for the City

The following broad health goals, which correspond to proposed health goals for Ontario, are not primarily the responsibility of the Department of Public Health; they require the commitment of City Government as a whole.

1. Reduce inequities in health opportunities in Toronto.
2. Create physical environments supportive of health.
3. Create social environments supportive of health.
4. Advocate for a community-based health services system.

The Department's Mission

Within the broad context of a City-wide initiative, the mission of the Department of Public Health is to help the people of the City make Toronto the healthiest city possible.

This mission can best be accomplished by:

- enabling the people of Toronto to increase control over and improve their health, both individually and as communities;
- developing and supporting a broad, multisectoral approach to the health challenges facing the City.

Health Goals for the Department

The following health goals are related to the proposed health goals for Ontario and are based upon the Department's present program priority areas. They represent areas for which the Department has primary responsibility.

1. Increase health expectancy among the people of Toronto.
2. Create healthful environments and protect the people of Toronto from health hazards.
3. Enable the people of Toronto to develop health promotion skills and achieve their health potential.
4. Plan for health and provide health data for the people of Toronto.
5. Promote and foster the Healthy City Initiative in all aspects of City life and government.

Three Priority Concerns

Three priority concerns should be addressed by *all* the Department programs.

1. In view of our concern with the need to reduce inequalities in health, our efforts must be to work with those with the greatest inequalities in health.

2. In view of the cultural diversity of Toronto, our efforts must be culturally appropriate and directed to those communities with the greatest inequalities.

3. In view of our concern with the need to empower people and communities, our efforts must be developed with the community, and must serve to facilitate the strengthening and empowerment of the community.

A Health Promotion Strategy

The five strategies of the Ottawa Charter should be used as the basis for developing the Healthy City Initiative.

Thus, as a City and as a Department we must:

- establish public policies that support health;
- create or help in the creation of environments supportive of health;
- strengthen and facilitate community action for health;
- develop or aid in the development of personal skills for health;
- reorient health services towards health promotion and a community-based health services system.

The Context

Like all big cities, Toronto's health has improved dramatically over the past century. This resulted from the actions of City government as a whole, community activists and social reformers. Life expectancy has increased by over 40 years as infant mortality rates have plummeted, as have infectious diseases. Much of this improvement has been due to such things as improved water supply and sewage disposal, better food quality and supply, better education (especially among women), better housing, living and working conditions, and public immunization campaigns. In the early part of this century, the Department of Public Health became one of the most respected municipal public health departments in the world, and its budget and resources grew dramatically under the leadership of Dr. Charles Hastings (1910-1929).

The development of medical technology and the advent of health insurance meant that less emphasis was paid to public health in the middle part of this century. However, beginning in the early 1970's, public health has undergone a renaissance.

The City of Toronto Department of Public Health again has assumed a leadership role and is fast developing an international reputation. This reputation is built upon good data-based planning, community development approaches, effective health advocacy, innovative programs and decentralized team management.

The past decade also has seen some dramatic improvements in health in Toronto, principally a 28 percent reduction in the standardized death rate, due particularly to a dramatic decline in deaths from heart disease. Other causes of death have declined substantially, including infant mortality, accidents, cirrhosis, suicide and male lung cancer. New epidemics also have appeared, notably lung cancer among women and AIDS.

These changes have occurred in the context of important new international, national and provincial thinking about health exemplified by the Ottawa Charter for Health Promotion; Health and Welfare Canada's report "Achieving Health For All: A Framework For Health Promotion"; three provincial reports which stressed health promotion and the establishment in Ontario of a Premier's Council on Health Strategy.

Community Development and Empowerment for Health

The theme of community development and empowerment for health runs throughout this Report, and is an important focus of "the new public health". Health promotion is defined as "enabling people to increase control over and improve their health". Facilitating the process of empowerment is a key strategy in health promotion.

The Changing City: Challenges to the Health of Toronto

While Toronto has a reputation for being a generally well run and livable city with a high level of health, there is an increasing sense that our generally favourable situation is under severe pressure. While Toronto is economically prosperous, this prosperity hides pockets of poverty, hunger, homelessness and general misery; while Toronto has a reputation for being clean and safe, it is becoming more crowded, overdeveloped, polluted and unsafe; while we have had an effective City government, good health and social services and a culturally diverse population living in harmony, these benefits can only be maintained through hard work and careful thought; and while life expectancy is high, infant mortality low and health status good, these figures disguise dramatic inequalities in health. These challenges need to be faced.

- The community's composition is changing in three important ways. First, the population is aging, with the proportion 65 and over expected to increase from 12 percent in 1986 to 24 percent in 2011. Second, our population has become much more multicultural, with 35 percent of the population of the City born outside of Canada, and only 39 percent of British origin. Third, the traditional family unit can no longer be taken for granted; there are more single parent families, more families with both parents working and a variety of alternative family structures.

- For some people in the City, the basic prerequisites for health are not met. Between 10,000 and 25,000 people in Toronto are homeless, while 30,000 to 40,000 are waiting for subsidized housing; unaffordable housing makes it difficult to afford other necessities of life. More people are hungry, with as many as one in twenty of the City's population receiving food from food banks while many do not eat nutritiously. For those affected by it, unemployment is devastating to physical, mental and social well-being, while much work is in itself unhealthy. The need for both parents to work is putting added strains on the family. Those with little education may have inadequate resources or knowledge to achieve good health; not only the one in four people who are functionally illiterate are at hazard, but those who do not receive adequate health education in school. There is some evidence that the disparity between the well-off and the poor is widening, and that children in particular are victims of poverty. It is not simply low income that is the problem, but the hopelessness that comes from long-term poverty and the lack of work opportunities and supports which would lead to self-reliance. Violence appears to be increasing, and a high proportion of women feel unsafe in their neighbourhoods. The ultimate violent threat to the City is, of course, nuclear war.

- Our physical environment is threatened by pollution and problems of waste management. We have to consider the health implications of urban planning decisions and we have to be concerned with our ecological and resource limits. Lake Ontario continues to be threatened by numerous sources of contaminants, some of which are entering the food chain. Huge new office developments will bring increased traffic and hence increased vehicle emissions. Our pollution of the environment and our use of the world's resources ultimately present a threat not only to ourselves but to the planet as a whole.

- While our health on the whole has improved, a number of major health problems still exist, and new ones have emerged. Heart disease continues to be the major cause of death, but as it has declined, cancer has increased. Substance abuse (tobacco, alcohol and drugs) contributes among other things to heart disease, lung and other cancers, liver disease, accidents, mental health problems and, in the case of injection drug use, to communicable disease such as AIDS and Hepatitis B. The emergence of AIDS is a major challenge to public health. Mental health problems are particularly challenging because of their complex and poorly understood origins and the deficiencies of our mental health care system.

- While Ontario has one of the best health care systems in the world, there has been an over-emphasis on the medical model and the institutional basis of the system. We need to move to a more balanced and community-based system of health care with more collaboration and coordination both within the system and between the health care system and other human services. Finally, we need to shift resources and emphasis to health promotion and disease prevention.

A Healthy City Initiative

A healthy city is not simply one whose population enjoys a high health status, nor is it one which has a healthy environment, though both of these are important results of a healthy public policy approach. Rather, it is one which recognizes the challenges to health and mobilizes its resources to meet them. It is, as the World Health Organization's background paper on healthy cities states:

> "... one that is continually developing those public policies and creating those physical and social environments which enable its people to mutually support each other in carrying out all the functions of life and achieving their full potential."

Clearly, this is a task that calls for health to be high on the agenda of all sectors of the community.

Of course, we cannot direct the actions of the community, nor even of City government. What we can do is propose to City Council and to the community, a strategy for a Healthy City Initiative — together with an outline of the Department of Public Health contribution to that initiative — and then work together to make Toronto more healthy.

The first component of the initiative is *a health agenda for Toronto* which addresses the basic prerequisites for good health - food, shelter, work, education, income, peace, ecological stability, resource sustainability, equity, and social justice.

This calls for the development by City Council of healthy public policies that will reduce inequities in health opportunities by ensuring that the people of Toronto have access to these basic prerequisites for health and will ensure that we create physical and social environments supportive of health. Thus we propose the establishment of the structures and processes needed to ensure that health is high on the public agenda: a Healthy Public Policy Committee is proposed together with a Healthy City Office. This agenda also calls for community empowerment to be a major concern of local government, so that individuals and communities can increase control over and improve their health. Proposed health goals for the City and the related programs are summarized in the Recommendations.

Within the overall Healthy City Initiative, it is appropriate that the Department of Public Health play a lead role in two areas: in the food area, because of the Department's responsibilities with respect to nutrition and in the area of environmental protection and developing a sustainable community strategy, through the Environmental Protection Office.

The second component of the initiative is a *healthy city strategy for the Department of Public Health* which addresses the Department's role not only in contributing to these four proposed Ontario health goals but in specifically meeting the remaining three goals:

The Department will meet those provincial goals, and carry out its own mission and provincially mandated programs through a wide range of programs organized in four goal-related program areas:

- community preventive health programs (programs directed at specific lifecycle stages, community locations and health problems) that increase health expectancy;
- community health protection programs which will create healthful environments and protect people from health hazards;
- community health promotion programs that help people acquire health promotion skills and achieve their health potential;
- community health planning and data programs that plan for health and collect and provide health data.

These goals and their related programs, are summarized in the Recommendations.

Each of the Department's programs will reflect the Department's three priority concerns:

- to reduce inequalities in health;
- to meet diverse cultural needs;
- to empower individuals and communities.

At the same time, the Department must pursue its fifth goal of supporting the Healthy City Initiative. To do so it must actively propose healthy public policies and work with other City departments and the community to ensure that the health agenda for Toronto is developed and implemented.

The relationship between the challenges to the health of Toronto and the proposed Healthy City Initiative is shown in Table 1.

Table 1

Challenges and Responses

	Challenges	Responses
3.1.1	An Aging Population	Healthy Seniors (see 4.3.1): - See also housing and health, urban planning and transport planning, accident prevention, community empowerment and support, a community-based health services system, promoting mental health, dental health.
3.1.2	A Multicultural Community	The need for the Department to address multicultural concerns in *all* of its programs is one of three priority concerns (see 1.7): - See also community development in a multicultural society, community empowerment and support, promoting mental health, healthy eating, health communications.
3.1.3	Changing Family Structures	Healthy Parents/Healthy Children (4.3.1): - See also income, work and health, community support, women, power and health, healthy seniors, health at school, health at work, communicable disease control, community development in a multicultural society.
3.2.1	Housing	Healthy Housing Policy (4.2.1): - See also income, work and health, urban planning for health, community sanitation and environmental protection.

3.2.2	Food	A Food Policy Council (Food For Health, 4.2.1) And Healthy Eating (4.3.1): - See also heart health, cancer prevention, dental health, community sanitation and environmental protection.
3.2.3	Work	Income, Work And Health (4.2.1) And Health At Work (4.3.1): - See also promoting mental health, community sanitation and environmental protection.
3.2.4	Education	Education For Health (4.2.1), Health At School (4.3.1) and Health Education (4.3.3): - See also healthy parents/healthy children, promoting mental health, heart health, cancer prevention, preventing substance abuse, healthy eating, dental health, healthy sexuality.
3.2.5	Income Distribution	Income, Work And Health (4.2.1): - See also housing and health, community empowerment.
3.2.6	Safety, Security And Peace	A Safe City (4.2.3): - See also urban planning for health.
3.3.1	Pollution And Waste Management	Urban Planning For Health (4.2.2), Community Sanitation And Environmental Protection (4.3.2): - See also a sustainable community.
3.3.2	Urban Planning	Urban Planning For Health (4.2.2): - See also transport planning for health, community sanitation and environmental protection.
3.3.3	Sustainability	A Sustainable Community (4.2.2): - See also urban planning for health, transport planning for health, community sanitation and environmental protection.
3.4.1	Inequalities In Health	The need to address inequalities in health in all the Department's programs was one of the three priority concerns identified in this report: - See also housing and health, food for health, income, work and

		health, education for health, community empowerment, community support, community development in a multicultural society.
3.4.2	Heart Disease	Heart Health (4.3.1): - See also cancer prevention, healthy eating.
3.4.3	Cancer	Cancer Prevention (4.3.1): - See also heart health, health at work, community sanitation and environmental protection.
3.4.4	Substance Abuse	Preventing Substance Abuse (4.3.1)
3.4.5	Mental Health	Promoting Mental Health (4.3.1) - See also community empowerment, community support, a safe city, women, power and health, healthy parents/healthy children, healthy seniors, health at school, health at work, preventing substance abuse, healthy sexuality.
3.4.6	AIDS	Communicable Disease Control (4.3.2), Healthy Sexuality (4.3.1).
3.4.7	Trauma	Accident Prevention (4.2.2) - See also transport planning for health.
3.5.1	A Community-Based Health Care System	Advocate for a Community-Based Health Services System (4.2.4).
3.5.2	Health Promotion	This Report.

Recommendations

Implementation Mechanisms

A Framework for Action

1. The Board of Health and City Council adopt the Framework for Action outlined in Section 1 of this Report.

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A Healthy City Initiative

A Healthy Public Policy Committee

2. City Council establish a Healthy Public Policy Committee to audit, monitor and coordinate the work of the City standing committees and departments with respect to enhancing the City's health and environment. This Committee would:

   - ensure that City policies are consistent with the proposed Framework for Action;
   - establish long-term health goals, objectives and targets for the City and a five-year plan for implementing the Healthy City Initiative;
   - develop and oversee the process of community involvement at all levels and in all sectors of the City in development and implementation of the Healthy City Initiative;
   - ensure that accessibility to City decision-making and to City services that affect health is open to the multicultural community;
   - oversee the work of the proposed Inter-departmental Healthy City Workgroup and the proposed Healthy City Office;
   - link with the Canadian Healthy Communities project, the World Health Organization (WHO) Healthy Cities project and with other Healthy City/Healthy Community projects in Canada.

A Healthy City Office

3. City Council establish a Healthy City Office to be located in an appropriate City department. This Office would be responsible for developing the City-wide Healthy City Initiative as outlined in this Report under the direction of the proposed Inter-departmental Healthy City Workgroup and the proposed City Healthy Public Policy Committee.

Inter-departmental Healthy City Workgroup

4. City Council establish an Inter-departmental Healthy City Work Group to coordinate the activities of the various departments involved in the City-wide Healthy City Initiative; the Workgroup would also oversee the work of the proposed Healthy City Office and would provide advice and consultation to the proposed City Healthy Public Policy Committee.

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Reduce Inequities in Health Opportunities in Toronto

Housing and Health

5. City Council, through the proposed Healthy Public Policy Committee and the Commissioner of Housing, establish a Healthy Housing Policy to complement and, where appropriate, reorient existing housing policy. The Policy should have the following objectives:

   - there will be no need for anyone to be homeless in Toronto;
   - while temporary hostel accommodation might be necessary from time to time, permanent housing will be available for all who need it;
   - appropriate and affordable housing will be available for low income families and for families with children to ensure a "healthy" social mix in the City;
   - a full range of supportive housing options will be available for senior citizens, and for those with physical and mental disabilities that would enable them to remain within the community;
   - emergency hostels and shelters will be available for assaulted women and their children, street youths and others in urgent need of shelter;
   - occupant control of housing will be strengthened;
   - speculation in housing will be controlled to help keep prices down;
   - all housing will meet minimum health standards.

Food for Health

6. City Council, through the proposed Healthy Public Policy Committee and the Medical Officer of Health, establish a Food Policy Council with representation from City Council, the private business sector, churches, community groups, nutritionists, environmentalists and others involved in food issues. The Food Policy Council should work to achieve the following objectives:

   - there will be no hungry people in Toronto;
   - there will be no need for food banks in Toronto;
   - an adequate, safe and nutritious food supply will be available to all citizens;
   - accessible food outlets will be within reach of all citizens;
   - Toronto citizens will be fully informed about the nutritional quality of the foods they consume;
   - food-related activities which degrade the natural environment and waste scarce resources needed for food production and distribution will be minimized.

7. The Department of Public Health play a lead role in the development of the City Food Policy and provide staff support to the proposed Food Policy Council.

Income, Work and Health

8. City Council develop an economic development strategy that will ensure the availability of healthful work that is environmentally sustainable and provides an adequate income.

9. City Council advocate for minimum wage and social assistance levels that will ensure everyone in the City receives an income adequate for good health.

10. City Council advocate for a supportive employment/reemployment assistance program that includes training/retraining, job search counselling and support services, such as daycare, for those seeking to reenter the work force.

Education for Health

11. City Council advocate to the Boards of Education the need for all students in both day school and continuing education programs to be functionally literate upon leaving school, to have mastered the skills that would empower them to participate actively in community life, and to have benefited from a comprehensive health education curriculum developed in consultation with the Ministry of Education.

12. The Department of Public Health collaborate with the Boards of Education toward the development of a comprehensive health education curriculum and the development of a health component in adult literacy programs.

Create Physical Environments Supportive of Health

Urban Planning for Health

13. City Council ensure that assessment of physical, mental and social impacts on health becomes a critical component of City of Toronto plan approvals.

14. The Department of Planning and Development and the Department of Public Health undertake a study of the impacts of increased density, including such issues as the health impact of commuting upon physical, mental and social well-being.

Transport Planning

15. City Council develop and adopt a vehicle emissions reduction strategy which includes some or all of the following:

    - reduction of the number of vehicles on City streets;
    - encouragement of public transit;
    - program to ensure that engines are properly tuned;
    - advocacy for a program to encourage less polluting alternative fuels;
    - encouragement of walking and cycling as alternatives to driving.

16. City Council take steps to improve safety for cyclists, including the consideration of developing physically separated bicycle lanes/pathways.

17. City Council request the Toronto Transit Commission to provide escalators and/or elevators at all transit stations, and to ensure that there is always at least one ascending escalator or an elevator.

Accident Prevention

18. City Council, through the Department of Buildings and Inspections, develop a program to "accident proof" homes, (particularly the homes of seniors); other accident prevention programs should be developed through the proposed Healthy Public Policy Committee.

Sustainable Community

19. City Council seek enabling legislation to permit the City to adopt an environmental by-law that includes:

    - an environmental bill of rights for the City;
    - amendments to the Official Plan to include environmental and health criteria;
    - legislation to promote a sustainable community.

20. City Council establish a sustainability strategy for the City (i.e., to include targets for resource and energy conservation, pollution control, recycling and waste management and the incorporation of sustainability criteria in the Offical Plan).

21. City Council establish policies and practices consistent with sustainability and health, including energy and resource conservation, recycling and the avoidance of toxic or environmentally harmful products.

22. City Council request Metro Council to establish a Metro Round Table on Environment and Economy, with linkages to the provincial and national Round Tables. Membership on the Roundtable should include business, community, government, health and environmental groups. The Round Table should have the mandate of developing a strategy for Metro Toronto becoming a sustainable community.

23. Through the Department of Public Health Environmental Protection Office, the City participate in the proposed Metro Round Table toward the development of a sustainable community strategy and environmental protection activities.

Create Social Environments Supportive of Health

Community Empowerment

24. City Council develop a Community Development Policy and facilitate community empowerment through its grants, through purchase of service agreements with community groups, where appropriate, and by ensuring that all City departments use community development approaches. In particular, the City should ensure that information on neighbourhood issues, resources and concerns is accessible and understandable at the community level and that children and adults acquire citizenship skills.

Community Support

25. City Council examine the desirability and feasibility of establishing or supporting volunteer coordinators in local communities, working in conjunction with voluntary groups, to develop and sustain a network of community volunteers.

A Safe City

26. City Council develop a broad-based "Safe City" Task Force to examine ways to reduce the level of violence in the community and to foster a more peaceful community.

27. City Council support and facilitate community-based action to reduce violence and increase safety.

28. City Council include a policy on public safety in the Official Plan.

29. The Department of Public Health report on the extent of violence in Toronto, its health impact and its antecedents.

Women, Power and Health

30. City Council evaluate the impact of its policies upon reducing the social, economic and health inequalities of women.

Advocate for a Community-Based Health Services System

31. City Council adopt a policy in favour of a more community-based health services system and ensure that the criteria for awarding grants from the Toronto Health Care Fund are consistent with this policy.

32. City Council use its influence through membership on the Metro Toronto District Health Council and hospital boards to advocate for a more community-based health services system.

33. City Council advocate, along with the Ontario Public Health Association, that the province shift 0.25 percent per year of the annual provincial health budget to public health and health promotion for ten years.

34. City Council advocate to the Ministry of Health for studies of the efficacy and cost-effectiveness of the current health care system.

35. City Council support the intent of the Metro Toronto District Health Council to develop a strategic plan for health promotion and health care that includes evaluation of the system's effectiveness and efficiency.

36. City Council request Metro Toronto District Health Council to adopt health goals for Metro Toronto consistent with the provincial health goals proposed by the Ontario Health Goals Panel.

37. City Council request Metro Toronto District Health Council to prepare a report on health inequalities in Metro Toronto and develop a strategy to attain health for all in Metro Toronto.

38. City Council request Metro Toronto District Health Council to commit itself to developing a community-based and community-managed health services sector at least as good as the institutional health services sector.

39. The Board of Health establish a forum that would be the basis for a coalition working to develop a community-based health services system in the City of Toronto.

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Increase Health Expectancy Among The People Of Toronto

Healthy Parents/Healthy Children

40. The Department of Public Health develop a Healthy Parent/Healthy Child Policy that emphasizes community development, family-based and culturally appropriate approaches. The Policy should:

    - advocate that parents and prospective parents have the information, physical and social resources necessary for healthy growth and development of both parent and child;
    - strengthen formal community services and support informal networks for mutual care and self-help;
    - strengthen the family's capacity to establish appropriate health promoting values, beliefs and behaviours;

    This will be accomplished through:

    - provision of direct services (including health promotion and education, health protection, disease prevention, screening, counselling and related services);
    - working with others in the community to ensure the provision of and advocate for services and resources for health (including daycare, housing, income support and other social support and mutual aid programs);
    - monitoring the health of parents, families and young children and identifying areas of need or concern.

41. The Department of Public Health programs for healthy parents and healthy children contain a significant mental health component, both to establish good parenting practices and to identify and help families at high risk of child neglect and/or abuse.

Healthy Seniors

42. The Department of Public Health greatly expand its activities in the implementation of its existing policy with respect to seniors.

43. The Department of Public Health consider the desirability and feasibility of establishing volunteer coordinators in each Health Area, working in conjunction with voluntary groups, with a particular responsibility to develop support and volunteer networks for seniors.

Health at School

44. The Department of Public Health work with the Boards of Education to develop a comprehensive health education curriculum; to promote and expand physical fitness programs, with an emphasis on non-competitive exercise programs; to ban smoking in all schools; to minimize the use of or eliminate toxic chemicals in the schools; and to advocate that only healthy food is provided/sold in schools.

45. The Department of Public Health provide school health services that are culturally sensitive and specific; and are provided more intensively to those in the community with the greatest health inequalities.

Health at Work

46. The Department of Public Health review its role in ensuring that small firms receive effective occupational health and safety services, and that their workers are informed on the use and hazards of toxic chemicals in their workplace.

47. The Department of Public Health develop workplace health promotion programs in collaboration with other health agencies, unions and employers, with particular emphasis on health promotion issues arising out of inequities in access to resources for health in the workplace.

48. The Department of Public Health investigate and report on a strategy to promote physical fitness programs in City of Toronto workplaces.

49. City Council ensure that those who work for City government have healthful work; this could be initiated by requesting the City's Occupational Health & Safety Committee to develop a "healthiest workplace possible" strategy.

50. The Occupational Health, Safety & Rehabilitation Division, Management Services Department be requested to work with the Department of Public Health to develop a City policy on health at work.

Promoting Mental Health

51. The Department of Public Health give much greater priority to mental health promotion and mental illness prevention. This should include:

    - parenting programs that are empowering and culturally appropriate;
    - programs to identify and work with high-risk families, such as the Parents Helping Parents program;
    - programs developed in collaboration with the Boards of Education and other appropriate community and parent groups that emphasize self-esteem, peer support, social networking and coping skills and resources for children;
    - mental health promotion programs in the workplace;
    - development of social networks and social support systems for seniors and others at risk of isolation, loneliness and vulnerability in thecommunity;
    - strong advocacy for an effective and comprehensive community mental health system;
    - monitoring and reporting on the status of the deinstitutionalized population;
    - research on mental health promotion and development of new mental health promotion programs.

Heart Health

52. The Department of Public Health collaborate with other health agencies, community organizations and all other relevant groups to develop a comprehensive heart health strategy with the goal of "shifting the curve" i.e., a strategy aimed at the population as a whole. This strategy should include:

    - programs to develop and reward the development of heart healthy food products and restaurant menus;
    - tobacco reduction/elimination strategy;

- culturally appropriate dietary goals;
- culturally appropriate fitness and exercise programs;
- heart health education programs;
- effective hypertension screening and treatment programs.

53. The Department of Parks and Recreation and the Department of Public Health collaborate in the development of wellness programs to be offered through the City's community recreation facilities.

Cancer Prevention

54. The Department of Public Health prepare a report on the scientific basis for a comprehensive cancer prevention strategy in the City of Toronto.

55. The Department of Public Health establish a comprehensive cancer prevention strategy (linked, wherever possible, to the Heart Health, Healthy Eating and Prevention of Substance Abuse programs). This strategy should include:

- tobacco reduction/elimination;
- cancer prevention diet;
- minimizing the use of and exposure to toxic chemicals at work, at home, in schools and in the community;
- appropriate cancer screening programs.

Preventing Substance Abuse

56. The Department of Public Health develop a comprehensive data-based substance abuse prevention strategy. This strategy should include:

- addressing the root causes of substance abuse such as addiction, isolation, loneliness, and stress,
- community-based alcohol and drug abuse prevention programs;
- participation with educational, enforcement, health and social agencies in intersectoral coalitions to prevent substance abuse;
- programs addressed to health professionals as well as the community to reduce prescription and over-the-counter drug abuse;
- collaboration with the Boards of Education to develop comprehensive substance abuse prevention and education programs.

Healthy Eating

57. The Department of Public Health, in collaboration with the proposed Food Policy Council, establish a Healthy Eating Program that includes:

- culturally appropriate dietary guidelines and nutritional goals;
- "right to know" by-law or provincial legislation which requires restaurants, food manufacturers and stores to inform people of the content of foods;
- working with food producers, manufacturers, distributors, retailers, unions, nutritionists and food advocacy groups to develop programs for healthy nutrition;

- advocating that only healthy food be provided or sold in schools;
- research on the costs to business, industry and society of an unhealthy diet;
- specialized dietary counselling as required.

Dental Health

58. The Department of Public Health advocate for the province to meet the dental health needs of those who lack either public or private dental insurance coverage through a program similar to the "Children in Need of Treatment" program.

59. The Department of Public Health continue to advocate for the province to develop a comprehensive dental treatment program for seniors.

60. The Department of Public Health continue to develop culturally and linguistically appropriate dental health programs and use community development approaches to enhance public awareness of dental health.

61. The Department of Public Health be involved in the research and development of new dental health approaches and development and adoption of new, efficacious and cost-effective prevention and treatment technologies.

Healthy Sexuality

62. The Department of Public Health develop a comprehensive healthy sexuality program that integrates all aspects of human sexual behaviour, and that reaches broadly into the community wherever young people and adults gather.

63. The Boards of Education make healthy sexuality an integral part of a comprehensive school health education curriculum.

Create Healthful Environments and Protect People From Health Hazards

Community Sanitation and Environmental Protection

64. The Department of Public Health consider the establishment of a restaurant food handler certification program and a nutrition awards program.

65. The Department of Public Health consider its role in the monitoring of chemical contamination of the food chain, and advocate to the provincial and federal governments for them to expand their monitoring, to undertake programs to reduce food chain contamination and to inform the public of its extent.

66. The Department of Public Health explore what role it can play in improving indoor air quality in the City of Toronto.

67. The Department of Public Health review the evidence that suggests environmental hypersensitivity is an important new public health problem and propose appropriate actions.

68. The Department of Public Health Environmental Protection Office actively participate in research for new techniques of health impact assessment.

69. The Department of Public Health consider a pesticide right-to-know by-law to complement provincial right-to-know legislation and undertake a comprehensive information and education campaign to ensure that the public are aware of toxic chemicals to which they are or may be exposed.

70. The Department of Public Health Environmental Protection Office assume a leadership role with respect to environmental protection.

Communicable Disease Control

71. The Department of Public Health play a significant role in infection control programs in both regulated and unregulated daycare facilities.

72. The Department of Public Health ensure the development of infection control programs in all collective living centres in the City of Toronto.

73. The Department of Public Health apply the lessons learned in endeavouring to control AIDS to the development and enhancement of other communicable disease control programs.

Enable the People of Toronto to Develop Health Promotion Skills and Achieve Their Health Potential

Health Promotion Skills

74. The Department of Public Health ensure that it has sufficient expertise in the areas of health education, community development and multicultural health, and undertake extensive and ongoing staff development in these areas.

Health Communications

75. The Department of Public Health continue to prepare culturally appropriate health communications, including communications suitable for those who are functionally illiterate.

76. The Department of Public Health examine ways in which the Department Resource Centre can make health information more readily accessible to the community.

Plan for Health and Provide Health Data

Health Planning

77. The Department of Public Health prepare a five-year plan, with objectives and targets for each program in this Report; biennial progress reports should be made to the Board of Health.

78. The Department of Public Health consider locating its planning function in the Office of the Medical Officer of Health.

Health Data

79. The Department of Public Health develop new data relevant to the City-wide Healthy City Initiative, including new Healthy City indicators; this information should be developed in collaboration with the proposed Healthy City Office and with the Canadian and World Health Organization projects.

80. The Department of Public Health prepare a report on health inequalities in the City of Toronto.

81. The Department of Public Health prepare neighbourhood health profiles that are easily understood and readily accessible; these should highlight issues relevant to inequalities in health status and to multicultural aspects of health.

82. The Department of Public Health report on the feasibility of providing a health data information service to the community.

83. The Department of Public Health develop new program data, including outcome measures, that will enable the Department to evaluate its progress with respect to the five-year plan.

Health Research

84. The Department of Public Health establish a Research Committee which should, as its first task, clarify the Department role in research and develop a health promotion/public health research strategy. The Research Committee should identify priority areas for research, with particular reference to the City-wide Healthy City Initiative, coordinate the Department research resources and seek research funds.

85. The Department of Public Health collaborate with the University of Toronto, York University, Ryerson Polytechnical Institute and others in developing health promotion initiatives.

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Support the Healthy City Initiative

Healthy City Strategy Section

86. The Department of Public Health consider establishing a Healthy City Strategy Section within the Office of the Medical Officer of Health to coordinate work with other departments, and provide linkages to the proposed Healthy City Office, the proposed Inter-departmental Healthy City Workgroup and the proposed City Healthy Public Policy Committee.

87. The proposed Healthy City Strategy Section provide health-related data and consultation relevant to all aspects of the City-wide Healthy City Initiative, and be responsible for developing analyses with respect to inequalities in health.

Staff Development

88. The Department of Public Health develop a long-term and comprehensive staff training and development strategy to ensure that all staff are aware of the Healthy City Initiative, such priority areas as health inequalities, community development and multicultural health issues and other matters. This staff training and development strategy should include a budget adequate to the task.

Education and Training of Community Health Professionals

89. The Department of Public Health collaborate with the University of Toronto, Ryerson Polytechnical Institute, Community Colleges and other centres in the education of community health professionals through formal Teaching Health Unit programs.

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Some Fundamental Concepts

Introduction

Ten years ago, the role, function and structure of the Department of Public Health was radically altered by the report, *Public Health in the 1980's*.

Today, a decade later, most of the recommendations in that report have been implemented, and the Department plays a far more active role in a wider range of public health issues. This has given rise to a new realization - that much that will promote or enhance the health of the people of Toronto lies "beyond health care" - as the Board of Health's centennial conference put it in 1984 - and beyond public health itself. It was this thinking that led to the "Healthy Toronto 2000" workshop that accompanied the "Beyond Health Care Conference" that year - a workshop that proved to be the inspiration behind the World Health Organization's "Healthy Cities" project and the Canadian "Healthy Communities" project, and of course, this Report.

This Report is not so much a paradigm shift - as was *Public Health in the 1980's* - as an evolution and refinement of our thinking since then. It recognizes that the process of improving the health of the community is slow and complex; that the profound changes in social values and attitudes that are necessary are the result of a long-term commitment to a multi-faceted and broad-based process of social change. Further, it addresses as much the City as a whole, and City government, as the Department of Public Health. To make Toronto the healthiest city possible, we must ensure that health is a principal concern on everyone's agenda, and that the health impacts of our decisions are recognized and taken into account. This is the central message of Healthy Toronto 2000.

How We Developed This Report

The Board of Health appointed the Healthy Toronto 2000 Subcommittee in 1986. Committee membership consisted of six Board members and five senior managers from the Department of Public Health, with staff support from the Department.

We began by inviting knowledgeable people from the academic world and the Department's own staff to brief us on the history of the Department and of public health in general, on current Departmental activities and future challenges to health in Toronto. At the same time, the Department prepared a review of the implementation of *Public Health in 1980's* and undertook a major "scan" of challenges to health in a number of areas outlined by the Subcommittee. Vision workshops, that helped to clarify our values and our desires for a healthy city, were held with the Subcommittee, over 200 Department staff and a number of community groups.

From all of this we developed a discussion paper on the major challenges to the health of Toronto and its citizens in the coming years. Over 1,500 copies of this paper, and over 5,000 copies of an abbreviated version were distributed in the community and to staff in late 1987. Both incorporated a questionnaire seeking advice on the major challenges to health, the steps necessary to make Toronto a more healthy city and the Department role in this process.

Nearly three hundred responses, representing many hundreds of people were received. (See Appendix II for a summary of responses to the survey.) In addition, Subcommittee members and Department staff made a number of community presentations, while public hearings in early 1988 received presentations and deputations from 26 groups and individuals.

This Report, then, is the result of extensive reflection and analysis as well as community and staff consultation and input.

1. The Healthy City: A Framework for Action

We begin our Report by laying out some of our fundamental beliefs about health and our basic public health values; our model of health; the need for a City-wide initiative for health; the mission and goals of the Department of Public Health; three priority concerns to be addressed by all programs; and, a health promotion strategy for the City and the Department. While this anticipates our description of the challenges to Toronto's health and our response to those challenges, we feel it is important to establish our framework right at the outset, since it is the core of our Report.

1.1 Some Fundamental Concepts and Values

We see health as a resource for everyday life. People wish to be healthy in order to lead rich and fulfilling lives, and to attain their maximum potential. In this context, health is more than just physical health - we have to pay much more attention to mental and social well-being. We recognize that the level of health of our community is a reflection of the quality of our community. Therefore the basic prerequisites for health must be available to everyone.

Health involves many factors which determine physical, mental and social well-being. We therefore need a sophisticated understanding of health, one which illuminates the complex interactions and the holistic nature of the determinants of health to guide us in our actions.

We have come to recognize certain fundamental public health values. These include:

- Promotion of health and prevention of disease are better than cure.
- Social interventions to enhance the common health of the community are appropriate and may take precedence over individual concerns.
- Inequalities in health must be reduced and their roots in social inequities must be addressed.
- We must treat our natural ecosystem with respect, both for our own benefit and for the benefit of future generations and we must provide for them a clean, green, quiet, healthy and sustainable environment.
- Our community must be human-centred and human-scale, a caring, sharing, cooperative and supportive community that places people above material things.
- Each individual in society needs a meaningful role and the opportunity to participate actively in the community and in decisions affecting their health.

1.2 A Model of Health

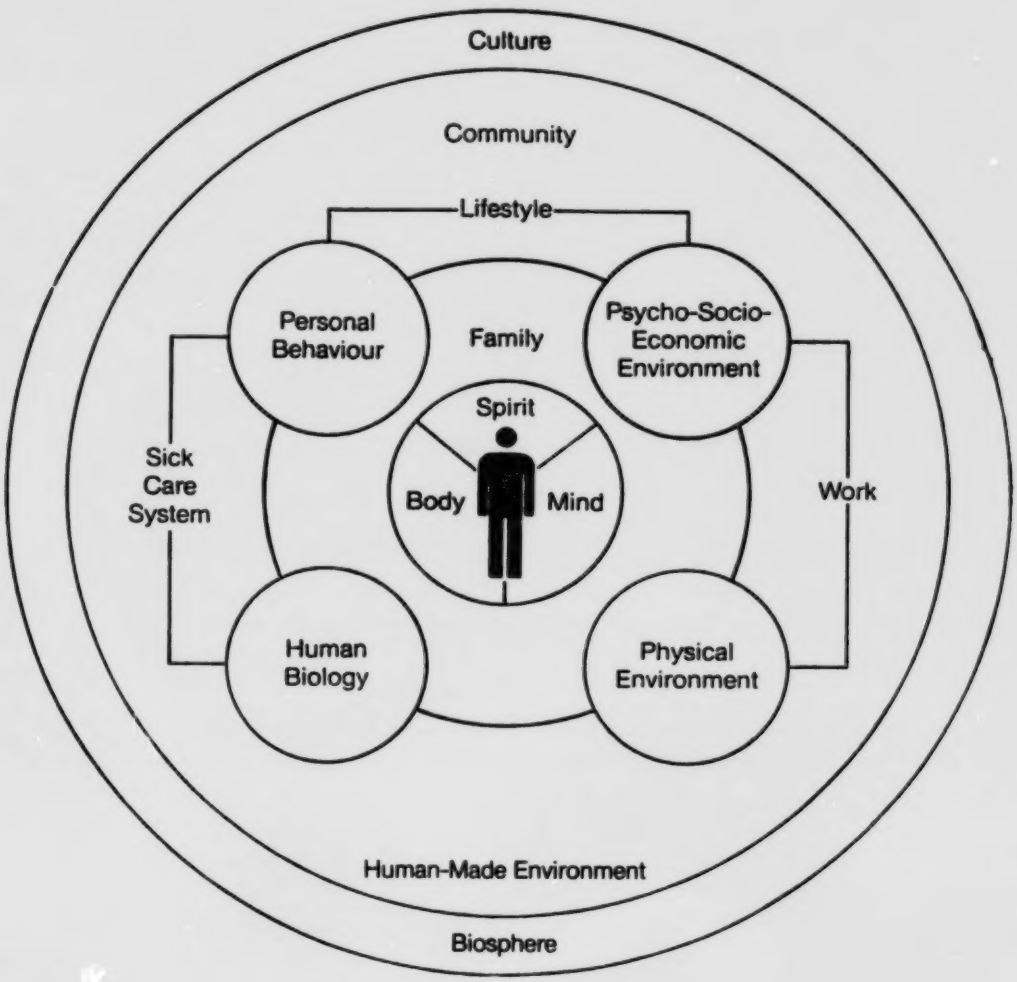
The Mandala of Health is a model of health that was developed by Department staff in the early 1980's and has since gained wide acceptance. It places the health of the individual at the centre of a complex and interacting set of health determinants. The most immediate influence upon the individual is his/her family, from whom s/he learns health habits, and from whom s/he receives both support and, on occasion, harmful influences. The individual's health and that of his/her family are in turn influenced by genetic inheritance and other aspects of human biology; by personal health behaviours and habits; by socio-economic status and psycho-social influences such as peer pressure and advertising; and by immediate physical surroundings at home, school and work and in his/her neighbourhood. The effect of work upon health is at least as much through the psycho-socio-economic environment as the physical environment. The sick (health) care system affects health almost entirely through the medium of human biology and personal behaviour.

"Lifestyle" - a much abused term - is not simply personal behaviour but is constrained and moulded by psycho-social and community influences. The latter, through shared values, formal and informal social supports and other mechanisms, has an important influence on health, and is subject to the influence of the wider industrialized culture of which we are a part. All of this takes place within the regional and planetary biosphere, the condition of which ultimately determines the well-being and even the survival of everyone.

This complex model of health is not static, but dynamic and interactive. While the individual is subject to all of these influences, it is equally important to recognize that the individual can affect them in turn. Thus, public health, to be fully effective, must be involved at one time or another in all of these spheres of activity, and must facilitate the empowerment of individuals and communities.

THE MANDALA OF HEALTH

A Model of the Human Ecosystem



1.3 A Healthy City Initiative

Recognition of the breadth of our concerns with health, compared to the somewhat narrower responsibility of the Department of Public Health, leads us to an inevitable conclusion: City government and the people of the City must become involved in any effort to make Toronto the healthiest city possible. This calls for broad, multisectoral and community-based initiatives which the Board of Health and the Department of Public Health cannot develop alone. Within this broad initiative, the Department must develop its own healthy city strategy.

1.4 Health Goals for the City

The following broad health goals, which correspond to proposed health goals for Ontario, are not primarily the responsibility of the Department of Public Health; they require the commitment of City government as a whole.

1. Reduce inequities in health opportunities in Toronto.
2. Create physical environments supportive of health.
3. Create social environments supportive of health.
4. Advocate for a community-based health services system.

1.5 The Department's Mission

Within the broad context of a City-wide initiative, the mission of the Department of Public Health is to help the people of the City make Toronto the healthiest city possible.

This mission can best be accomplished by:

- enabling the people of the City of Toronto to increase control over and improve their health, both individually and as communities;
- developing and supporting a broad, multisectoral approach to the health challenges facing the City.

1.6 Health Goals for the Department

The following health goals prepared for the Department are based upon its present program priorities and are also related to the proposed health goals for Ontario.

1. Increase health expectancy among the people of Toronto.
2. Create healthful environments and protect the people of Toronto from health hazards.
3. Enable the people of Toronto to develop health promotion skills and achieve their health potential.
4. Plan for health and provide health data for the people of Toronto.
5. Promote and foster the Healthy City Initiative in all aspects of City life and government.

1.7 Three Priority Concerns

Three priority concerns should be addressed by *all* Department programs.

1. In view of our concern with the need to reduce inequalities in health, our efforts must be to work with those with the greatest inequalities in health.

2. In view of the cultural diversity of Toronto, our efforts must be culturally appropriate and directed to those communities with the greatest inequalities.

3. In view of our concern with the need to empower people and communities, our efforts must be developed with the community, and must serve to facilitate the strengthening and empowerment of the community.

1.8 A Health Promotion Strategy

The five strategies of the Ottawa Charter should be used as the basis for developing the Healthy City Initiative.

Thus, as a City and as a Department we must:

- establish public policies that support health by putting "health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health";
- create or help in the creation of environments supportive of health, recognizing that "health cannot be separated from other goals of our complex society; the inextricable links between people and their environment constitute the basis for a socio-ecological approach to health";
- strengthen and facilitate community action for health - "at the heart of this process is the empowerment of communities, their ownership and control of their endeavours and destinies";
- develop or aid in the development of personal skills for health - "by providing information, education for health and enhancing life skills...(we) increase the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health";
- reorient health services towards health promotion and a community-based health services system - "the role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services".

Recommendation 1:

The Board of Health and City Council adopt the Framework for Action outlined in Section 1 of this Report.

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2. The Context

Toronto has been widely recognized as a livable city, a city that works. An important contribution to Toronto's reputation is its high level of health and its innovative approach to public health. The improvement of health in Toronto and the development of new thinking about health has not occurred in isolation. In this introduction, we review the history and concepts which provide a background for our Recommendations.

A Brief History of Public Health

2.1 A Century of Progress

Like all big cities, Toronto's health has improved dramatically over the past century. This resulted from the actions of City government as a whole (not just the Department of Public Health) and the actions of community activists and social reformers, as well as the actions of provincial and federal governments and the health care system. A concern with the health of the public and the resultant need to develop a 'health-enhancing City' was evident in the establishment of a number of City departments over the past 150 years. Of 36 civic services created since the City's incorporation in 1834, health concerns were a major factor in the establishment of ten of them, principally in connection with concerns about sanitation, clean water, good housing, safety, health and social services.

A hundred years ago, the health of Toronto's citizens (95 percent of them of British origin (Figure 1) left a lot to be desired. It is estimated that in 1881, just before the Department of Public Health was established, the average age at death was 25 years for men and 27 years for women; by 1981 this had risen to 68.3 and 73.7 years respectively. Most of this increase was due to the dramatic decline in infant mortality rate, from 193 deaths per 1,000 live births in 1908 to 7.9 per 1,000 in 1986. This has been accompanied by a marked decline in the general fertility rate, from 120 births per 1,000 women aged 15 to 44 in 1883 to 48 per 1,000 in 1983 (Figure 2). As the population grew from 86,415 in 1881 to 612,290 in 1986, the proportion of the population 65 and over rose from 2.8 percent in 1881 to 12.0 percent in 1986; thus the actual number of people 65 and over has grown from 2,420 to 73,265 over that period, a thirty-fold increase (Figure 3).

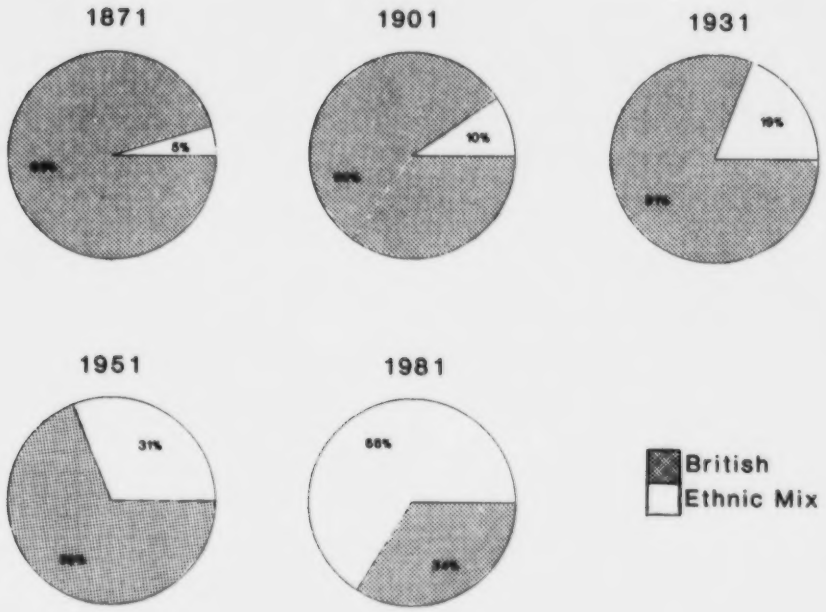
Not only are we living longer today, the pattern of cause of death also has changed dramatically. The major causes of death in 1883 were infectious diseases, representing approximately 20 percent of all deaths; by 1983, they accounted for only 0.8 percent of deaths. On the other hand, circulatory, cancer and other non-infectious diseases increased from 39 percent of deaths in 1883 to 55 percent in 1983, while deaths due to accidents and violence increased from 2.7 percent of deaths in 1883 to 7.2 percent in 1983.

But as indicated in the quotation at the beginning of this Report, most of the improvement in health has been a result of such things as improved water supply and sewage disposal, better food quality and supply, better education (especially among women), better housing, better living and working conditions and public immunization campaigns. City government, often in response to pressures from community activists and social reformers, contributed significantly to this improved health through the activities of such departments as the Abattoir, the Board of Works, the City Engineer, the Housing Authority, the Parks Department, the City Architect, the Water Works Commission and, of course, the Department of Public Health.

The strength and effectiveness of the Department of Public Health has been an essential part of Toronto's improved health, and here Toronto has been both fortunate and far-sighted in its commitment. Under the outstanding leadership of Dr. Charles Hastings, Medical Officer of Health from 1910 to 1929, the Department became one of the most respected municipal public health departments in the world. Its mandate grew until it included such concerns as industrial hygiene, (occupational health and safety) social welfare, housing, school health and "municipal housekeeping", which taught women the principles of hygiene and sanitation, diet and nutrition, child rearing and care of the sick. Under Hastings' leadership, the Department of Public Health resources also grew dramatically. The annual budget increased ten-fold and the nursing staff increased from two in 1910 to 110 by his retirement in 1929. It was during his tenure that City water was chlorinated, sewage filtration plants were built and milk was pasteurized. In this period the City also established an Abattoir, a Housing Commission and a Street Cleaning Commission.

FIGURE 1

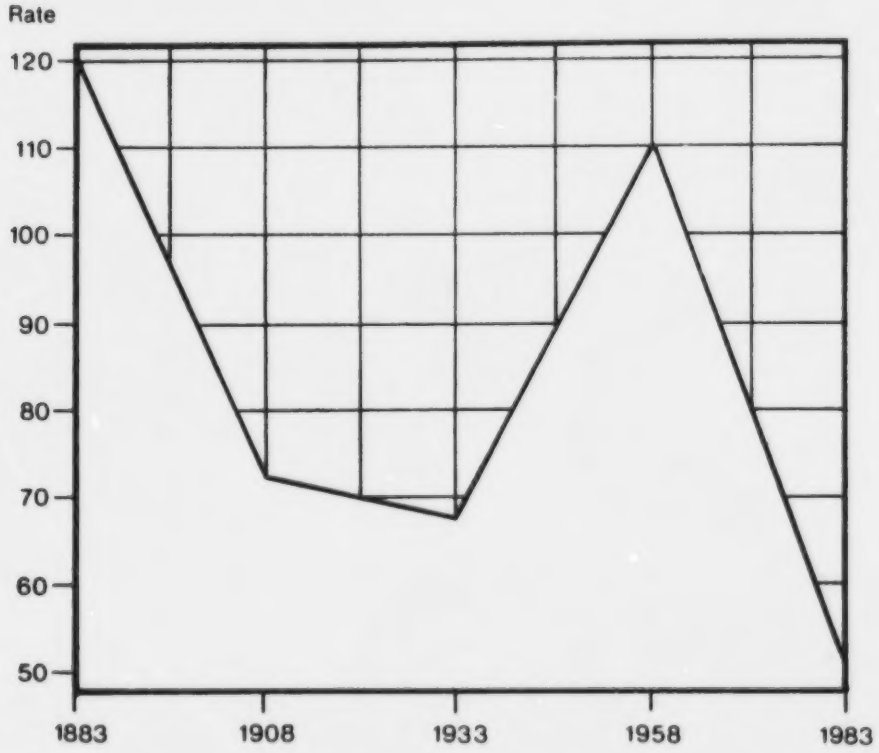
TORONTO'S ETHNIC MIX 1871 - 1981



Source: Toronto 150
Statistics Canada, 1984

FIGURE 2

GENERAL FERTILITY RATE★ IN WOMEN AGED 15 TO 44 YEARS
CITY OF TORONTO, 1883 - 1983



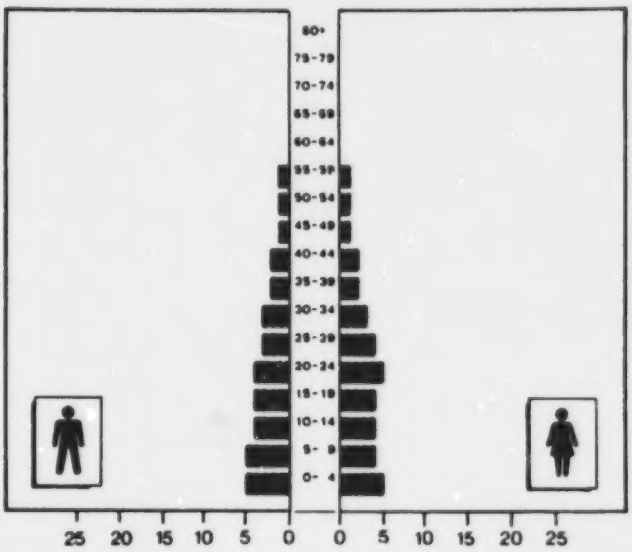
★ Per 1,000 female population

Source: Health Status Report
Department Of Public Health, 1983

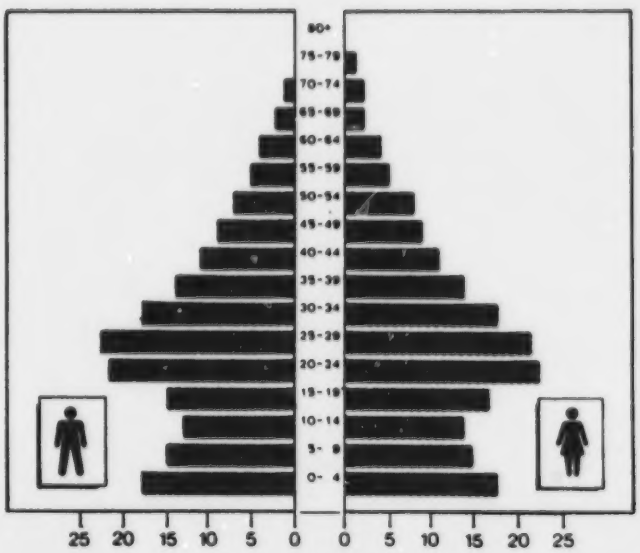
FIGURE 3

POPULATION OF THE CITY OF TORONTO (IN THOUSANDS)
BY 5-YEAR AGE GROUPS AND SEX, 1881 - 1981★

a) 1881



b) 1911



Source: Health Status Report
Department Of Public Health, 1983

The fruits of all these efforts were seen quickly. In 1914, Macleans Magazine was able to boast that Toronto had the lowest death rate in the world of any City with a population of over 350,000; the mortality rate from typhoid fever was reduced by 90 percent between 1910 and 1915; the City's last deaths from smallpox and diphtheria were recorded in 1932 and 1934 respectively.

During the 1930's, things began to change. The discovery of antibiotics and the subsequent development of a whole host of new pharmaceuticals and improved diagnostic, therapeutic and surgical techniques led us to focus upon the medical care system and to neglect the role of public health. Indeed, one can see an increasingly narrow focus in our understanding of health, moving from a focus on the environment to a focus on the community and the family, and ultimately to a focus on the individual. Public health, with its emphasis on environmental and community approaches, seemed to have little to contribute, and came to take a passive back-seat role.

After the second world war, the medical, diagnostic and treatment approach dominated the health care field. National hospital and health insurance plans, which ensure universal access to health care, were the major focuses of health policy. Society became preoccupied with the technology of modern medicine and health became synonymous with doctors and hospitals; the focus narrowed again, from the individual to the organ, the cell and, ultimately the molecule. The contributions of public health organizations were not recognized and appreciated, nor was the holistic and environmentally-based public health model.

The Renaissance Of Public Health

2.2 A Decade of Change

Ironically, and perhaps inevitably, the heavy emphasis on the medical approach began to be questioned only a few brief years after the establishment in 1971 of a national system of provincial health insurance plans. In 1974, the federal government published *A New Perspective on the Health of Canadians* (the Lalonde Report). This report had a dramatic effect on our approach to and understanding of health, internationally, nationally and locally. The report showed that a health care system was only one determinant of the health of Canadians, and that future improvements in health would result primarily from changing environments and lifestyles.

This approach was taken in Toronto, and in 1976 the Board of Health established the Health Planning Steering Committee. Their 1978 report - *Public Health in the 1980's* - defined a new direction for municipal public health. Declaring that the Department could not be "all things to all people", the report called for the determination of priorities and for a Department that would be responsive to changing needs. It reestablished the importance of a community-oriented public health approach to problems previously considered to be merely medical.

The report emphasized social, environmental and lifestyle determinants of health and identified new directions for the Department. It recommended a functional reorganization designed to enhance the Department's capacity in data-based planning, research, health education and media promotion, community development and health advocacy. It also called for a structural reorganization to provide for decentralization, team management and community consultation.

In the past decade, the Department staff implemented the great majority of the recommendations of *Public Health in the 1980's*, including virtually all of the administrative recommendations and many of the program recommendations. This was made possible because of the efforts, energy, enthusiasm and innovation of a dedicated staff who have adapted to the demands of this new public health.

A health advocacy unit was established in 1979, which later became the core of Central Resources when the Department was reorganized. In 1982, the Department established four Health Areas providing personal health, environmental health and inspection, preventive clinical and support services managed by multidisciplinary teams. At the same time Community Advisory Boards were set up in each Health Area. An extensive and sophisticated health status data-base was developed, and a community health survey was conducted in 1983.

In 1982 the Department also adopted a mission statement - "To make Toronto the healthiest city in North America" - and a set of program priorities, including:

- optimal health for parents and children;
- prevention of death and illness due to tobacco, alcohol and drug consumption;
- reduction of mortality and morbidity due to premature heart disease;
- prevention of suicide;
- reduction of occupational health and safety hazards;
- reduction of health hazards in the environment;
- increase of primary prevention programs;
- full development of primary prevention skills among Department staff;
- increased awareness among the people of Toronto of health issues and the work of the Department;
- development of a comprehensive data-base on health status;

- increased access by staff to complete information in their fields of specialization and the health field in general;
- evaluation of Department programs.

The Department is pursuing these priorities. Policies and programs in parent and child health, school health, mental health, heart health, dental health, and seniors health have been reviewed. For example, the school health work group reported in 1986 that "health promotion through the educational system is the greatest opportunity we have to make a difference in the positive health habits of our citizenry". The group recommended that the Department role in schools be mainly prevention and education while still meeting the legislative and mandated service delivery programs. The dental health review led to fundamental changes in the Department's philosophy and programs, with more attention paid to seniors and those at highest risk. The mental health policy review proposed four general goals: the reduction of preventable mental health problems, adequate care for all mentally ill persons, enabling communities to achieve optimum mental health and ensuring that the City of Toronto is a social and physical environment that fosters optimal mental health. "The Department is committed to community development as one of the primary strategies for improving the health of the City", the report says, "...the very process of organizing a community to identify and respond to its health needs is a mental health promoting process."

Given Toronto's rich mix of peoples, multiculturalism has also become a focus for the Department.

The Department has provided educational material for staff and the community including an award-winning film that examines the relationship between poverty and ill health. The Department recognizes that, from a health perspective, housing problems include homelessness, affordability and quality of housing. It has been active in both FACT (the Food Advocacy Coalition of Toronto) and Foodshare, which address the health implications of hunger.

Major studies and reports on lead pollution, the Junction Triangle, drinking water quality, PCBs and community right-to-know legislation have been undertaken by the Department. City Council established an Environmental Protection Office in the Department. This Office represents a unique inter-departmental collaboration, and demonstrates the feasibility of City-wide interdepartmental approaches to large health problems. The Environmental Protection Office provides research and investigation services to City government, including environmental health assessment of chemicals, the review of some development applications, the provision of information services and research into substances safer than those in current use.

This brief overview of the Department's major activities and concerns cannot do justice to the breadth and depth of its activities. The public health nursing staff are extensively engaged in home visiting, including young pregnant women, newborn babies and the "old old". A variety of educational and health promotion programs have been developed for specific groups, such as Healthiest Babies Possible, a program to provide prenatal education and nutritional supplementation to pregnant women at high risk of having low birth weight infants; Parents Helping Parents, a mutual support program for parents at high risk for developing parenting problems; a variety of school health promotion programs such as Passport to Health; wellness programs for seniors and so on. A large amount of public health nursing time is spent providing health education and services in Toronto schools. Other nursing staff are involved in programs of immunization, smoking prevention, mental health and the control of sexually transmitted and other communicable diseases.

The Department's public health inspectors are involved in an extensive program to ensure food safety, through regular inspections of the City's food premises and educational programs for food handlers. They play an important role in the investigation and management of cases of communicable diseases, particularly those in institutions or related to

food. An extensive environmental hygiene and health program involves them in investigations of biological and chemical threats to health in our environment.

An extensive dental program is provided in schools and collective living centres, involving education, dental hygiene services and treatment services. Programs are carried out in the area of family planning, hearing conservation, nutrition, community development and public education. Central Resources provide expertise in data collection and analysis, epidemiology and planning, promotion and education, research, and program development.

This represents merely the highlights of the Department's activities. Those interested in more information are referred to the extensive documentation available from the Department, in particular the Annual Statements. It would be remiss, however, to fail to mention that in 1986 the Department received a two-year accreditation from the Ontario Council of Community Health Accreditation, indicating the high standards of the Department's current administration and organization.

2.2.1 Changing Health Status

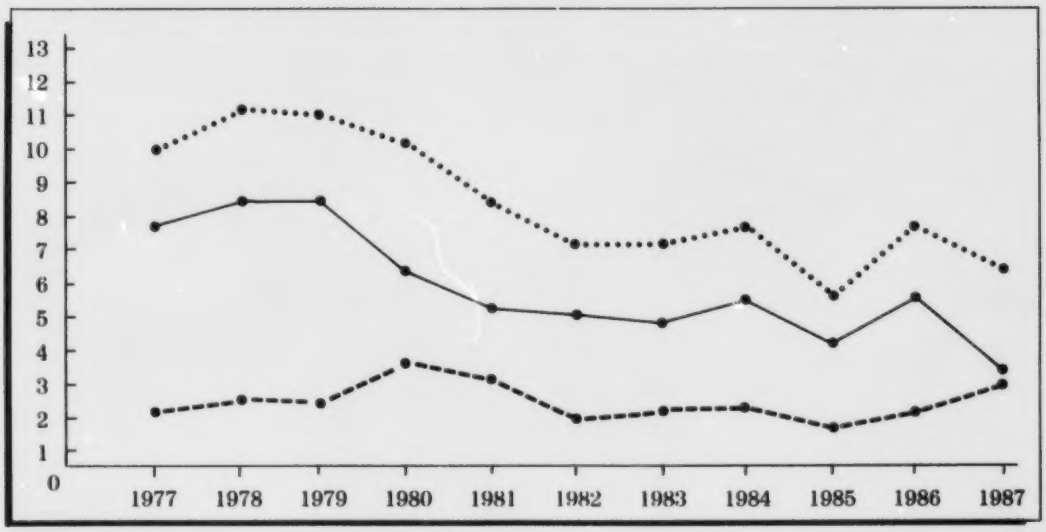
There have been some important changes in health status over this period. Average age at death has increased slightly for males, from 65.3 years in 1977 to 67.3 in 1987 (varying between a high of 68.3 in 1981 to a low of 65.3 in 1977), while for women it has increased more dramatically and more steadily, from 72.6 years in 1977 to 75.9 in 1987. The infant mortality rate has declined in that same period from 10.0 per 1,000 live births to 6.5 per 1,000, while the perinatal mortality rate declined from 13.1 to 5.9 per 1,000 (Figure 4). The standardized death rate from all causes has fallen 28 percent, from 759 per 100,000 in 1976 to 546 per 100,000 in 1986. There has been a particularly dramatic decline in mortality from cardiovascular disease, which almost halved from a standardized rate of 332 deaths per 100,000 in 1976 to 176 in 1986; among males, the standardized mortality rate from myocardial infarction and ischaemic heart disease★ fell nearly 60 percent in that period. Other declines in standardized mortality rates between 1976 and 1986 include accidents (down by more than a half), cirrhosis (down 41 percent) suicide (down a third), male lung cancer (down 24 percent) and all cancer (down 12 percent) (Figure 5). However, lung cancer mortality among women has increased by almost 75 percent while mortality rates from breast cancer have declined by less than three percent. This, coupled with the dramatic decline in heart disease mortality has meant that the number of deaths from heart disease and cancer were nearly the same in 1987, whereas in 1977 there were approximately 50 percent more deaths from heart disease than cancer (Figure 6).

In the past decade we have seen the emergence of AIDS as a major new threat to health - the leading cause of death among males aged 35 to 44 and the third leading cause of potential years of life lost among men in 1986. It is a dramatic reminder that the era of infectious diseases is not entirely in the past.

★ The term "cardiovascular disease" includes all causes of death resulting from disease of the heart and blood vessels, including stroke. "Heart disease includes rheumatic heart disease, hypertensive heart disease, and inflammatory or infective heart diseases as well as myocardial infarction (MI) and ischaemic heart disease (IHD). Most cardiovascular disease deaths are due to heart disease, and most of these are due to MI and IHD.

FIGURE 4

INFANT MORTALITY RATES 1977 - 1987
PER 1,000 LIVEBIRTHS



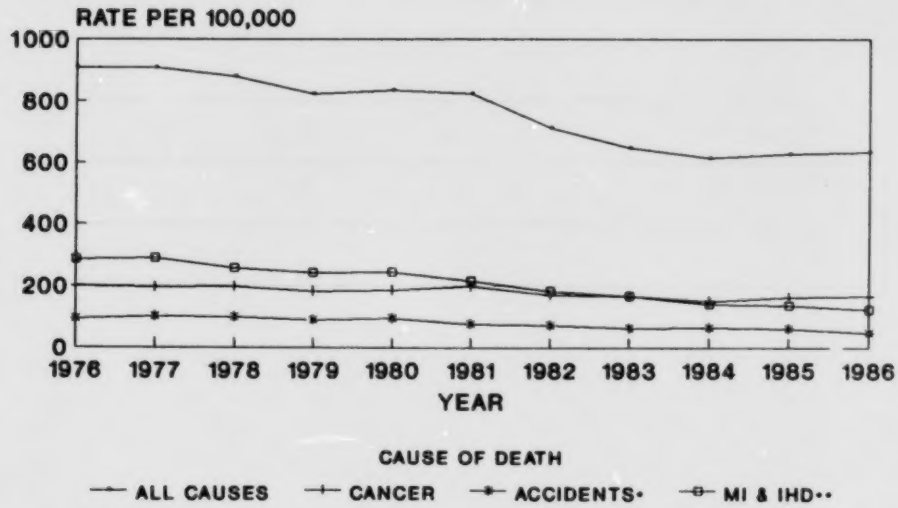
—— Neonatal (less than 28 days old)
- - - Postneonatal (from 28 days to under 1 year old)
• • • • Total

Source: Annual Report, 1987
Department Of Public Health

FIGURE 5

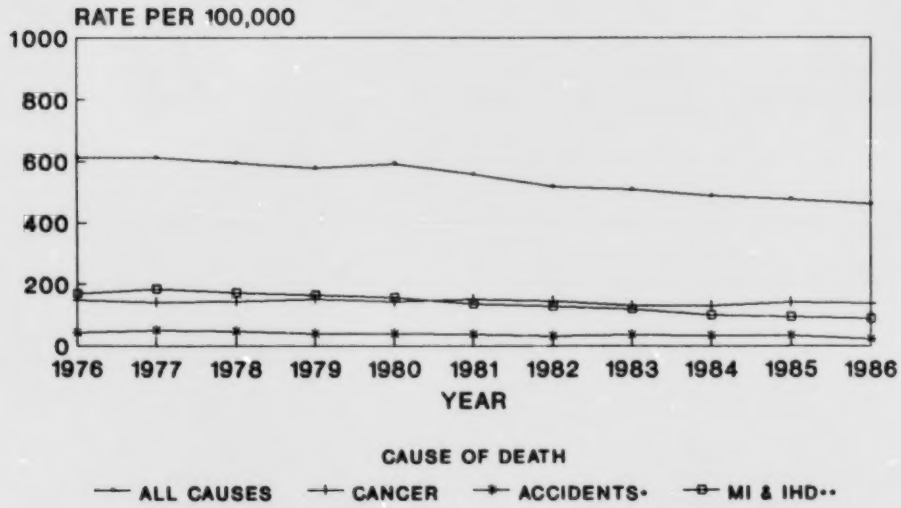
PRINCIPAL CAUSES OF DEATH FOR MALES AND FEMALES, 1976 - 1986
STANDARDIZED RATE PER 100,000 POPULATION

STANDARDIZED MORTALITY RATES IN MALES
CITY OF TORONTO, 1976-1986



• Includes accidents,poisonings,violence
••Myocardial infarction & ischaemic heart disease

STANDARDIZED MORTALITY RATES IN FEMALES
CITY OF TORONTO, 1976-1986

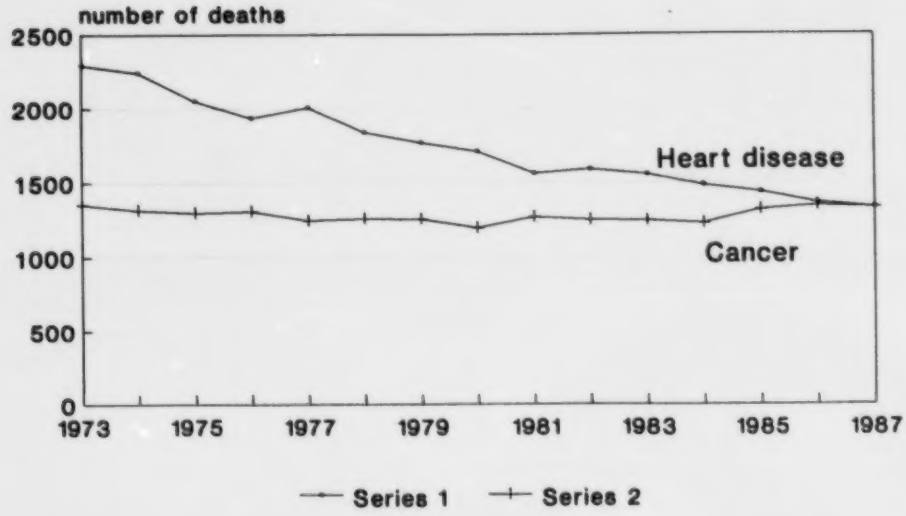


• Includes accidents,poisonings,violence
••Myocardial infarction & ischaemic heart disease

Source: Community Health Information Section
Department Of Public Health

FIGURE 6

HEART DISEASE & CANCER DEATHS,
CITY OF TORONTO, 1973 - 1987



Source: Community Health Information Section
Department Of Public Health

2.3 New Thinking on Health

New ideas about health are not, of course, limited to the City of Toronto. The past decade also has seen a major rethinking of health globally, nationally and provincially. In 1977, the World Health Organization proclaimed the goal of "Health For All by the Year 2000" - by which it meant the attainment of "a level of health that enables people to lead socially and economically productive lives". Health is now seen in terms of quality of life and as "a resource for everyday living", and thus an objective for governments and societies as a whole, using what the WHO referred to as the "multisectoral approach," or "healthy public policy".

In the 1980's, the concept of "health promotion" emerged among the industrialized nations of the world. Health promotion is defined as "the process of enabling people to increase control over and improve their health". At an international conference held in Ottawa in 1986, five broad health promotion strategies were recognized in "The Ottawa Charter for Health Promotion". They are:

1. To build healthy public policy.
2. To create supportive environments.
3. To strengthen communities.
4. To develop personal skills.
5. To reorient health services.

At this same conference, the Canadian strategy - "Achieving Health For All; A Framework for Health Promotion" was unveiled (Figure 7). It stresses the need to reduce inequities both in health status and access to basic prerequisites for health.

In Ontario, three major reports released in 1987 further developed these new approaches. The Ontario Health Review Panel (Evans Report) called for more emphasis on the individual responsibilities of citizens with respect to their health, innovations in the health care system directed towards collaboration and community-based initiatives and the establishment of a Premier's Council on Health Strategy to develop healthy public policies for Ontario. The establishment of the Premier's Council in late 1987 indicates the importance the government attaches to this approach.

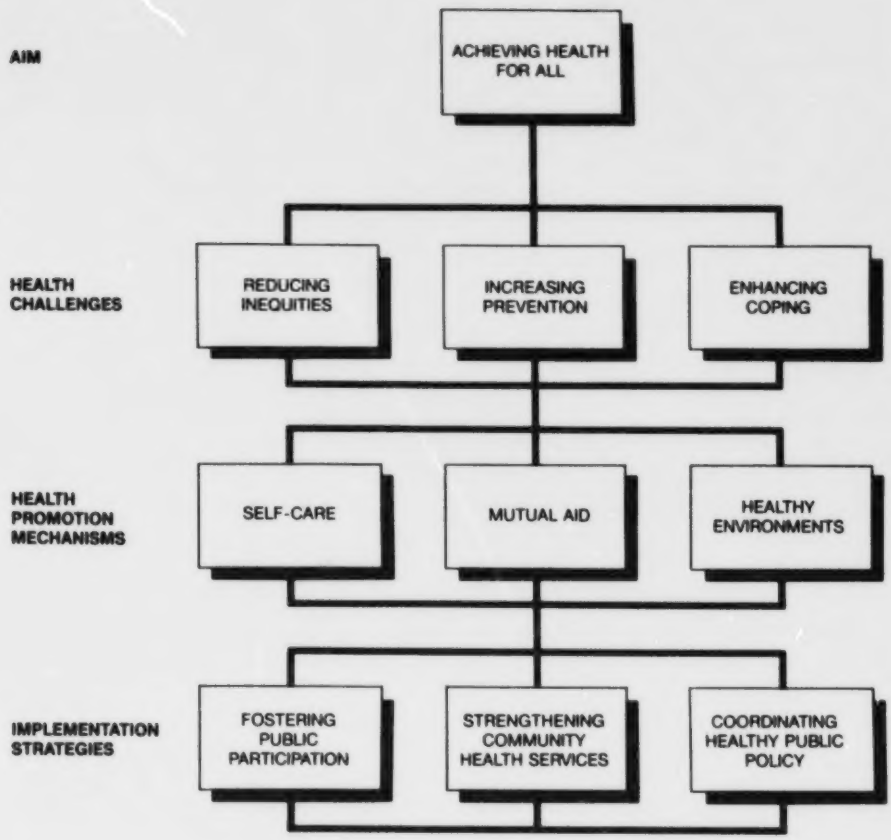
The report of the Panel on Health Goals for Ontario (Spasoff Report) identified a set of seven broad health goals for the province. These are:

- Achieve equity in health opportunities.
- Enable Ontarians to achieve their health potential.
- Increase the health expectancy of Ontarians.
- Provide environments which support health.
- Encourage behaviours which support health.
- Provide health services which support health.
- Establish public policy which supports health.

These goals, which are supported by 30 more specific sub-goals, provide a blueprint for achieving health for all in Ontario.

FIGURE 7

A FRAMEWORK FOR HEALTH PROMOTION
(HEALTH & WELFARE CANADA, 1986)



Source: Achieving Health For All
Health & Welfare Canada, 1986

The report of the Minister's Advisory Group on Health Promotion (Podborski Report) examined health promotion initiatives at the community level. They found Ontario communities were ready, willing and able to take action to make their communities better places to live and noted that the public health sector is the prime candidate to assist in the local "empowering process". Identifiable roadblocks to better health included environmental pollution, stress, a lack of basic fairness in the meeting of human needs and provision of important services, and poor personal health habits. Need was seen for support of local action, effective participatory leadership, building bridges between the many sectors of the community and government ministries and the need to bring policy makers closer to the people.

In short, these recent Ontario Government reports emphasize and support the strategies and approaches exemplified by the Ottawa Charter for Health Promotion. Taken as a whole, this rethinking of health, to which the City of Toronto Department of Public Health has made a significant contribution, provides a basis for action for the coming years. We are in a position to capitalize on our existing strengths to ensure that Toronto will be an even more healthy city in the years ahead.

2.4 Community Development and Empowerment for Health

One of the most important themes running through the new thinking about health is the concept of community development and the related concept of empowerment. Indeed, health promotion is defined in terms of empowerment and the strategy of strengthening communities. The Ottawa Charter refers explicitly to empowerment, expressed as "ownership and control of their own endeavours and destinies". Since this is destined to be a major thread running through our Report, we wish to clarify our definition.

When we talk of a *community*, we mean a specific group of people, defined by geography and/or by affinity (e.g., occupation, ethnicity, gender, sexual orientation, interests), who exhibit some awareness of their identity as a group, and where the group is of a nature and size that direct access to decision-making is possible.

By *community development* we mean "the process by which a community decides collectively on its needs and develops strategies to utilize its collective power to meet their needs." (OCDA, 1986) In health promotion terms, it is "the process of involving a community in the identification and reinforcement of those aspects of community life, culture and political activity which are conducive to health." (WHO, 1986).

By *empowerment* we mean, quite simply, the ability to make choices, which requires both information and power. Both in individual and collective terms, a sense of ownership and control is central to good health.

As should be clear from the above, an agency such as the Department of Public Health cannot develop or empower a community; what it can do is facilitate the process of community development and empowerment through such processes as the development of indigenous leadership, mobilization of community support and the formation of networks and coalitions. What it must not do is provide programs and services which encourage the community and its members to become dependent on the agency.

Challenges for the 1990's

3. The Changing City: Challenges to the Health of Toronto

In this section of the Report, we identify a number of threats to the health of Toronto's citizens and challenges to the Department of Public Health. These challenges were initially determined on the basis of the environmental scan, and were subsequently refined as a result of community and staff response to the discussion paper. The consultation indicated that the major challenge to health we face is homelessness and lack of affordable housing, closely followed by environmental pollution. Poverty, hunger and poor food quality were seen as the next significant challenges to health, while the aging of the population, the multicultural nature of the population, unemployment/underemployment, and violence also ranked high. These challenges, of course, are in addition to the more commonly accepted hazards to health posed by smoking, alcohol and drug abuse, poor nutrition, lack of exercise.

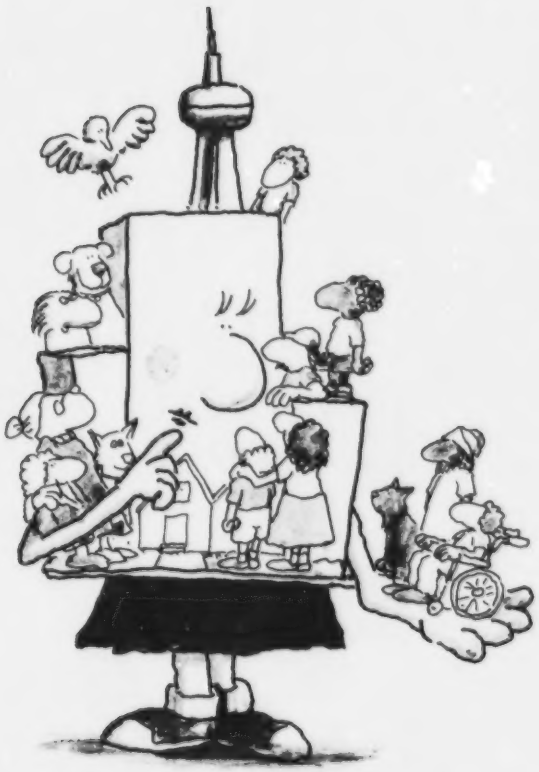
In terms of the Department's role in responding to these challenges, pollution, poor food quality, hunger, and the aging population were pre-eminent. While the community saw the Department as playing an important role with respect to homelessness, the Department staff did not; they saw addressing the challenge of a multicultural community as more important. (See Appendix II for a summary of the responses)

We list the challenges under five headings, namely the community's composition, the community's social condition, its environment, the community's health and the community's health care system.

Before turning to the challenges, we wish to make it clear that these challenges occur within a context of generally good health and a generally well-run and livable city, attributes that are widely recognized elsewhere in the world. Certainly in comparison with the challenges faced by the cities of the developing world, we are very fortunate.

There is an increasing sense, however, that our generally favourable situation is under severe pressure. While Toronto is economically prosperous, this hides pockets of poverty, hunger and homelessness; while Toronto has a reputation for being clean and safe, it is becoming more crowded, over-developed, polluted and unsafe; while we have had an effective City government, good health and social services, and a culturally diverse population living in harmony, these benefits can only be maintained by a dint of hard work and careful thought; and while life expectancy is high, infant mortality low, and health status good, these figures disguise dramatic inequalities in health.

One of the attributes of a healthy and successful city, surely, is that it does not hide its problems but acknowledges them and moves in a determined fashion to deal with them effectively, building on its existing strengths, resources and capabilities. It is in this context that we identify and address the challenges to Toronto's health and the health of its people.



The Community's Composition

3.1 The Community's Composition

Three major changes in the community's composition pose important challenges to health. The first of these is the aging of the population, the second is the multicultural nature of our society and the third is the change in family structures.

3.1.1 An Aging Population

Demographic projections show that Toronto's population is aging. It is expected that the proportion of the population 65 and over will increase from 12 percent in 1986 to 21 percent in 2000. The aging population will be somewhat better educated, with more people born outside Canada and with more females than at present. Seniors are expected to be healthier. But, because they will represent a greater proportion of the population, the total number in poor health will likely be greater.

- The number of elderly is increasing. The elderly will also be living longer. In 1981, 37 percent of seniors in Canada were age 75 or older. By the year 2000, 46 percent of Canadian seniors will be age 75 or older.
- In the year 2000, among those 65 and older, there will be 50 males for every 100 females. Of the females, 40 percent will be over age 75.
- In 1981, 74 percent of the income of elderly females was from government sources compared with 59 percent of that of males. However, in the future, older women will likely have somewhat better pensions gained through employment.
- 38 percent of those 65 and over in Metro in 1986 were living alone. In the future, more older women will live alone.
- 7.3 percent of seniors 65 and over in Ontario lived in some form of institution in 1986, as did 15.5 percent of those 75 and over; a further 12 to 13 percent of those 65 and over needed support to function in the community.
- There is evidence of a negative attitude towards the elderly. With more seniors, the potential for intergenerational strife will increase.

The aging of the population poses a number of challenges, including: the need to ensure that people enter their senior years in good health, that they remain active and involved; that they retain their independence and ability to live at home and in the community as long as possible, and that there are support services to ensure a dignified old age and death with dignity.

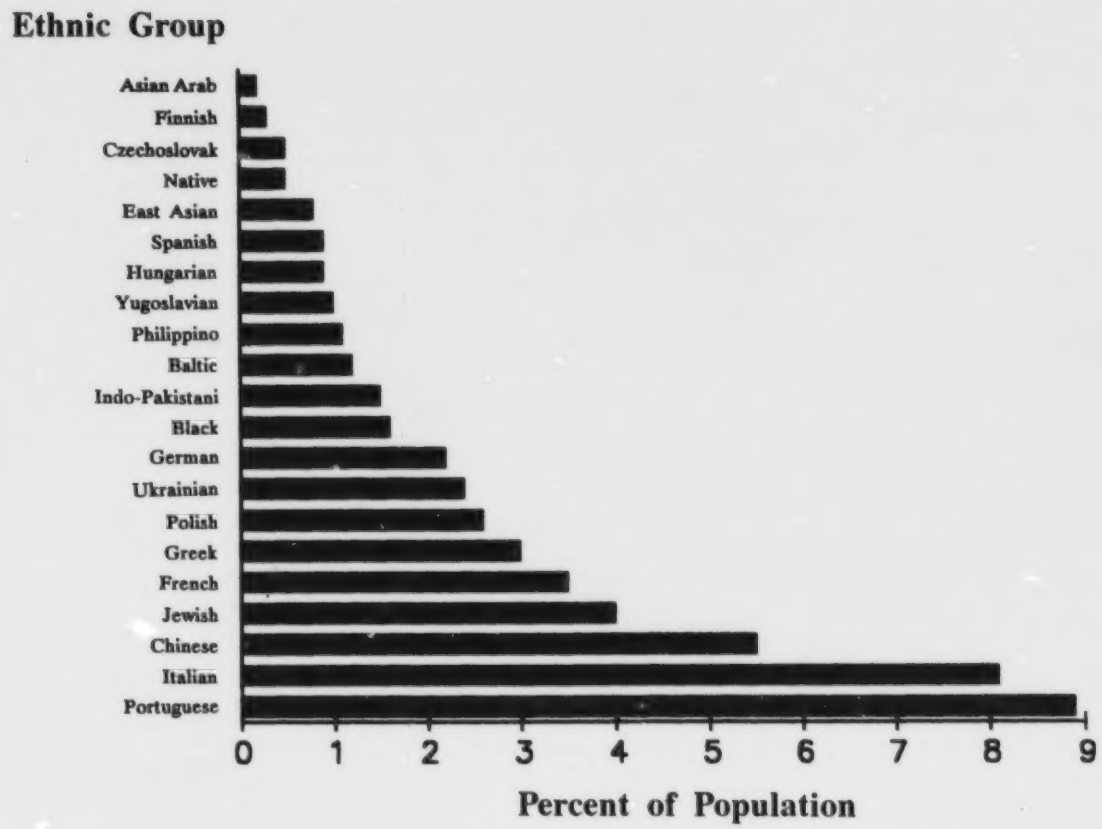
3.1.2 A Multicultural Community

Thirty-five years ago the population of Toronto was predominantly British; immigration in the 50's was largely from Europe.

- 1981 figures show that 35 percent of the population of the City of Toronto was born outside of Canada. In the same year only 39 percent of the City population was British in origin. Of the other major groups, nine percent were Portuguese, eight percent Italian and six percent Chinese in origin (Figure 8).
- While Native people are not considered as part of our immigrant multicultural society (Status, Non-status, Metis, and Inuit), they are a significant proportion of our population. It is estimated that there are at least 30,000 Native people in Metro, and they are expected to grow to 50,000 by 2000.

FIGURE 8

Ethnocultural Origins (Non-British) Of
City Of Toronto, 1981



Source: Statistics Canada, 1981 Census
Ethnocultural Data Base, Ontario
Ministry Of Citizenship And Culture

- Since 1971, the proportion of immigrants coming from Asia, Latin America and Africa has increased, while the proportion coming from Europe has declined.
- The proportion of elderly (65 +) in the longer established immigrant groups (principally British and East European) is generally close to 20 percent.
- In 1984, 49 percent of immigrants to Canada from the ten leading source countries chose Ontario as their destination. Thirty-one percent of all immigrants to Canada came to Metro Toronto.
- In 1984 the major sources of immigration to Metro Toronto were the Caribbean, Guyana, Hong Kong, Vietnam, and India. Thirty-two percent of all immigrants were under 21, with only seven percent over 65.
- Studies show that in 1984, immigrants and refugees were generally well educated; 69 percent with grade nine or more, 52 percent fluent in English; however, a high proportion of the longer established immigrant groups have less education and are employed in lower status occupations.
- The Government of Canada has adopted a policy of moderate, controlled growth in immigration. Levels will rise to an average of 150,000 a year by the end of the 1980's and remain there.

Toronto will continue to be a major reception area for new Canadians. For many of them, the difficulties and stresses of life in a new country will be compounded by low paid work, poor housing and other problems that will affect their health. It will be a challenge for the Department to work with these groups to facilitate their empowerment in dealing with such concerns.

The multicultural nature of our community is also a key challenge to public health and the health services in Toronto. The various concepts and beliefs about differing expectations of health care services demand a culturally and linguistically appropriate response. The Department must expand its commitment to working with Toronto's multicultural communities to promote health and to ensure that services are available and accessible.

3.1.3 Changing Family Structures

The traditional family unit can no longer be taken for granted. The divorce rate will probably stabilize. The impact of AIDS on family life and sexual behaviour is unpredictable. Alternative family structures including same sex and intergenerational groups will increase; families will be smaller. More single-parent families, more families where both parents work, and the advent of a national daycare program, will mean increasing daycare enrollment. More people are living alone, or with unrelated others.

- The proportion of households in the City of Toronto that are "family" (single or dual parent plus children) declined from 87 percent to 52 percent between 1951 and 1986; 37 percent of 1986 households were single persons.
- While it is difficult to determine, it is estimated that 40 percent of marriages now end in divorce. In the future, divorce rates will probably stabilize and common-law unions will increase.
- 27 percent of families with children in Toronto in 1987 were headed by a single parent; 83 percent of single parents are female.
- In Toronto the proportion of all first births that were to women 19 years and younger declined between 1976 and 1986 from 17.6 percent to 8.4 percent, while the proportion of all births to women 35 and older increased from 2.9 percent to 9.4 percent.
- It is typically estimated that ten percent of the City's population, or approximately 60,000 are gay men and lesbians. The 15,000 to 20,000 who annually participate in Lesbian and Gay Pride Day support the estimated size of this "community." Many

of these individuals have come to live in Toronto because of the lack of support and isolation in smaller communities across Canada and because there is a visible "community" for them to identify with here.

These changes pose a number of challenges to health. The increase in single households could lead to more loneliness and less social support, which will have an adverse affect on mental and physical health. The high rate of marital failure will continue to pose problems in terms of stress and potential family violence, while the large number of female single parent families calls for changes in work structures, improved daycare and other supports.

The Department must understand how to work with diverse families and units of people. Despite the relative openness in the City of Toronto to differences in family units and to gay and lesbian individuals, stigmatization towards these groups in the provision of services is often reported. The Department can take a lead role in increasing awareness of the needs of these groups at City Hall and in community services. Alternative family structures and gay and lesbian individuals come from a variety of ethnic, socio-economic and religious backgrounds. The Department can take a lead role in assisting the community-at-large in accepting the diversity which exists within each identifiable grouping.

Prevention of family violence and sexual abuse of children will be paramount. Pre and post-natal and other family-based programs to high-risk parents will need to be given priority.

Because of increased daycare the Department will need to re-examine its role in infection control, nutrition, quality of care, infant stimulation and the training and education of daycare workers. This may require shifting resources from the elementary and high schools to daycare centres and other preschools.

3.2 The Community's Social Condition

The World Health Organization identifies a number of prerequisites to health, including peace, food, shelter, work, education, and income. People who are homeless, hungry, unemployed, uneducated, poor, or living in violent circumstances cannot be healthy. Yet there are many people in Toronto for whom one or more of these problems exist.

3.2.1 Housing

Three aspects of housing are pertinent to health in Toronto: homelessness and lack of affordable housing; housing for individuals with special needs; housing as it affects the quality of life.

- The number of homeless people in Toronto is estimated to have risen from approximately 3,500 in 1982 to between 10,000 and 25,000 in 1986; one estimate is that as many as half of the homeless have or have had mental health problems.
- On average over 2,000 hostel beds were occupied in Metro Toronto every night in 1987; 1986 data suggest that a high proportion of hostel clients are from the City of Toronto, that over half are age 16 to 24, that over 3,000 children age six or under were admitted and that one-third of the 1,600 families (75 percent of them single-parent) were admitted because of spousal violence.
- Households should not spend more than 30 percent of their income on shelter if they are to have enough for the other necessities of life. In Ontario in 1984, families and single people earning the equivalent of social assistance benefits spent 50 percent and 75 percent respectively of their income on shelter; in Metro Toronto in 1986, 75 percent of social assistance recipients spent more than 40 percent of their income on shelter.
- Approximately 8,500 low income single people in Metro Toronto require housing assistance.
- Approximately 30,000 to 40,000 people, representing around 15,000 households were waiting for subsidized housing in Metro Toronto in June 1987.

- Approximately 2,000 discharged psychiatric patients have inadequate housing.
- At least 3,800 institutionalized, physically disabled adults could live in the community if appropriate attendant care and accessible housing were available.
- *Living Room II: A City Housing Policy Review* (1986) says that gentrification, condominium conversion and housing costs downtown will force major changes in the distribution of families and singles.
- The City's housing stock is aging and needs rehabilitation; unfortunately, shortages and rehabilitation costs may force people to live in substandard housing.
- From 1980 to 1986 an average 2,160 units per year were lost to demolition, conversion or luxury renovations. Losses of private rental stock apartments and tenant/owner occupied stock totalled more than 20,000 units.
- Many low income single parent families (especially those headed by women) live in physically inadequate housing because of the high price of homes and the continuing discrimination against children by some landlords.
- Of the approximate 21,000 single people on General Welfare Assistance in Metro Toronto in January 1988, almost nine out of ten reported they spent more than 50 percent of their income on shelter.

It may be said that homelessness affects a relatively small percentage of Torontonians, but it is a hardship symptomatic of the dearth of affordable housing. Of particular concern is the relationship between homelessness and mental health problems - each problem compounds the other.

Inadequate housing is a problem for the most vulnerable groups with whom the Department works - single parent families, those with physical and mental disabilities, the working poor, low income singles and seniors. Seniors are particularly vulnerable to housing issues such as property tax reassessments; the restrictive zoning by-laws and other legislation that stifle creative housing programs designed to foster mutual aid; static or declining financial resources; and critical service gaps. High housing costs force many on low incomes to forego food, clothing and other necessities of life.

The government's policy of deinstitutionalization (which we support as an ideal) challenges us to ensure a range of available, affordable supportive housing and service options for people with special needs. Poor housing is a threat to health and well-being, particularly for children and senior citizens. The Department must continue to be involved in housing issues and policies.

3.2.2 Food

Adequate nutrition is a basic need and prerequisite for health. Optimal nutrition contributes to improved health, growth, intellectual development, work performance, resistance to infection and feelings of well-being. Poor nutrition contributes to low birth weight, cardiovascular disease, hypertension, cancer, diabetes and weight problems. Ongoing access to appropriate and acceptable food (food security), depends on personal income, education, personal rights, food choice, food quality, and physical accessibility, and may be influenced by advertising and marketing practices.

- The number of food banks has increased dramatically since 1981. There are now 171 emergency food programs in Metro Toronto, and 165 in the rest of Ontario.
- A one week survey of food program clients in 1987 found that 63 percent were on general welfare assistance or family benefits, while 11 percent were employed; 70 percent had lived in Metro Toronto ten or more years; half the households were families, 20 percent of the recipients of food aid were under age 5, and 45 percent under age 20.

- Toronto's largest food bank distributed almost ten times as much food in 1987 as in 1985; 23,500 families (55,000 persons) were supplied each month, almost two-thirds of whom were from the City of Toronto, equivalent to one in 20 of the City's population.
- In the 1980 Canada Health Survey, the prevalence of heart disease, known to be related to nutrition, was 33 percent in the lowest income quintile and 16 percent in the highest.
- As much as one-third of cancer may be related to diet.
- Food contains large numbers of synthetic chemicals, some deliberately placed there as colourings, flavourings, preservatives and other food additives; some are there unintentionally through contamination of the food chain with dioxins, PCBs and other pollutants.
- The Consumer Price Index for food in the City of Toronto rose more rapidly between 1981 and June 1988 than in other Canadian cities; it was 142.2 (1981 = 100) in Toronto, 139.0 in Montreal, 130.0 in Ottawa and 128.9 in Winnipeg.

There is no systematic collection of information on the prevalence, duration and intensity of hunger in Canada. What is known is inferred from the 1971/72 Nutrition Canada Survey. These data show that Canadians with limited incomes are at higher nutritional risk than those with higher incomes.

While people in Toronto are not facing starvation, at least five percent of the population, both adults and children, face involuntary food shortages. Heart disease, obesity, some forms of cancer and bowel disorders are associated with inadequate and poor nutrition. The Department must stress the impact upon health of food shortages, poor food quality, poor food habits and related problems.

Although levels of chemical residues in food have been decreasing for several years, they are still present. Many foods also contain additives. Because it is likely that a significant portion of human exposure to many chemicals occurs through food, we should be examining ways of reducing levels of these chemicals in food.

3.2.3 Work

Work is not merely a source of income but a vital part of mental, social and cultural well-being.

> "Our work is an assertion of our humanity. Work provides us with the means for physical survival, but it also engenders feelings of self-worth, purpose, belonging, and contribution to the community."
>
> (Canadian Mental Health Association, 1984)

A recent Canadian Mental Health Association report on *Work and Well-being: The Changing Realities of Employment* (1984) makes the following points:

- Working together well is good for health and for business;
- The work ethic and a stable family life are the two pillars of our culture; yet there are growing conflicts between career development and a healthy and stable family life;
- Working women face this conflict in an extreme form because rewarding employment opportunities are fewer than for men and the demands of family life upon them are all too often unrelieved, placing health at risk.

Persistent high levels of unemployment are detrimental to well-being and are an unacceptable waste of human resources.

- Unemployment rates for youth are consistently higher than for adults; at a time when adult unemployment in the City is as low as 3.2 percent, youth unemployment is 8.0 percent. The rate is higher for City youth than for youth in the Census Metropolitan Area, where it is 6.4 percent.
- By the year 2000, manufacturing and agricultural jobs in Canada will have declined to 20 percent of the work force. But by 1985, industry accounted for only 13 percent of employment in the City, while office work accounted for 64 percent.
- Most new jobs will be in the service sector, where often wages are lower, benefits are less comprehensive and part-time work is more common; 26 percent of families headed by a part-time worker lived in poverty in Ontario in 1984, compared to seven percent with a full-time worker.
- While many Canadians find themselves with no employment, others are forming new and higher expectations of work - people want their work to be fulfilling and meaningful.
- Developing technologies, human rights legislation, and education will continue to produce changes in the workplace.

Unemployment will continue to contribute to poor health for those affected, through loss of income and loss of self-esteem. In some cases, the problem is not that work is unavailable but that people are unemployable - they have been unable to acquire the necessary skills for employment.

Underemployment, temporary, part-time, poorly paid or unfulfilling work undermines health because of loss of benefits, security and certainty on the one hand and boredom and frustration on the other. A more equitable distribution of work and its benefits will be necessary. The conflict between family life and work life, especially for women, calls for a more equitable sharing of both domestic work and paid work between men and women, with attendant shifts in work conditions, daycare, parental leave and other supports.

There is growing evidence of the relationship between demanding jobs that give little control over decision-making to the worker and a wide variety of health problems, including heart disease. This suggests that the way work is organized and managed presents a major challenge to health, beyond the more traditional concerns of physical health hazards that have been the preoccupation of occupational health and safety programs.

3.2.4 Education

As with inadequate income, lack of education is related to poor health. Those with little education may have inadequate resources or knowledge to achieve good health.

- A recent National Survey carried out for Southam News found that 27 percent of the population of Toronto are functionally illiterate.
- Sixty-eight percent of women in Ontario who are not in the labour force are considered functionally illiterate.
- Thirty percent of high school students in Ontario do not graduate with a secondary school graduation diploma.
- In a 1982-83 survey of the health knowledge of Ontario students, Grade 10 students' answers were inadequate on 60 percent of questions asked. Grades 4 and 7 students were better informed for their age groups.

Functional illiteracy not only compromises people's health learning and their ability to earn a living and provide the necessities for health, it may also be a direct hazard to health, because such people may not be able to read warning labels, or to distinguish harmful

from harmless products. Lack of health knowledge works against improvement in health status. The Department will need to continue to work in schools, focusing on the development of comprehensive health education programs about lifestyle and the prevention of chronic diseases, and will need to become concerned about the health hazards of illiteracy.

3.2.5 Income Distribution

Poverty is linked to hunger, homelessness, unemployment and stress. There is evidence of an increasing disparity in income as "the rich get richer and the poor get poorer". Single people, single-parent families, women, the elderly and the disabled are critically affected. In the next decade economic growth will probably be slow and wages will lag behind, leading to further erosion of disposable income. "Deep poverty" (families or individuals with an income less than 60 percent of the low-income level, defined by Statistics Canada) is increasing.

- A 1986 National Council of Welfare report showed that the average income of the poorest 20 percent of Canadian households declined eight to ten percent between 1980 and 1984.

The recently released report of the Social Assistance Review Committee found that:

- 1.2 million people, or 13.8 percent of all residents of Ontario lived in poverty in 1984, as did 16 percent of children. More than 20 percent of families with three or more children and 55 percent of female single parent families lived in poverty.
- "The majority of the poor receive no money from social assistance at all ... (they) receive their income from earnings."
- "A minimum wage job has never yielded sufficient income to provide adequately for the costs of raising a family, but today the minimum wage provides an insufficient income to support even a single person in many parts of Ontario ... Since 1979, the gross income from employment at minimum wage has lost about 20 percent of its value."
- "By any of the widely recognized benchmarks of adequacy used in Canada today, the incomes of social assistance recipients are inadequate."

Other evidence of the challenge posed by inadequate income and problems of income distribution include:

- In 1980, the City of Toronto had the highest proportion of low-income households of all Metro municipalities.

  (Detailed income data from the 1986 Census will not be available until 1989).
- One-third of single elderly men and half of single elderly women live in poverty, but because of government income supplements they are less likely to live in deep poverty than are poor children and youth. Poverty is even more acute among younger men and women.
- Overall, single people are three times more likely to be poor than people living in families.
- Fifty-seven percent of the poor in Canada are women. This national trend is evident in Toronto.
- In Ontario communities of over 500,000 population, the 1984 child poverty rate was 28 percent, a 37 percent increase over 1981. Child poverty is concentrated in large urban centres such as Toronto.
- Fifty-eight percent of poor families in Canada are headed by one employed person; 17 percent of families that have immigrated since 1960 live in poverty.

There is a clear relationship between low income and poor health. This is as true in Toronto as elsewhere in the industrialized world. The increase in deep poverty is of urgent concern, as is poverty among vulnerable groups such as children and seniors. But it is not simply low income that is the problem; the real problem is the hopelessness that comes from long-term poverty and the lack of work opportunities and supports (e.g., adequate minimum wage, daycare, benefits) to encourage self-reliance and independence from government social assistance programs. The Department must continue to be involved in issues of poverty and health, and in attempting to facilitate the empowerment of the powerless.

3.2.6 Safety, Security and Peace

Violence, especially violence against women, family violence, child abuse and elder abuse appear to be increasing. Further, there is concern about increasing violence towards minority groups in the City of Toronto. Although the level of violent crime is low in Canada compared with the United States, the fear of crime and violence on the streets and in the community is a mental health issue. The portrayal of violence on television and in other media needs to be addressed.

- In general, crime rates in Metro Toronto are lower than in cities such as Montreal, Edmonton and Vancouver; however, crime rates are higher in downtown Toronto (52, 14, 51 and 55 Divisions) than in Metro Toronto as a whole.
- Nonsexual assaults in Metro Toronto increased from 11,500 reports in 1983 to 19,400 in 1987, while sexual assaults nearly doubled, from 1,262 to 2,219; women were the victims of 45 percent of non-sexual assaults and 85 percent of sexual assaults.
- A 1987 survey found that 38 percent of women feel it would be somewhat or very unsafe to walk alone at night in their neighbourhood, while 63 percent felt that way about walking alone in downtown Toronto; over 40 percent reported they were more afraid than they were five years previously.
- One in four girls and one in eight boys reportedly suffers from child abuse; nearly one in three victims of sexual assault reported in 1987 were age 11 or under.
- In 1985, 19 percent of murders and 15 percent of assaults in Toronto involved spousal violence.
- In the United States government sponsored report on Violence Against Minorities, homosexuals were said to be probably the most frequent victims of hate violence.
- Abuse of older people is predicted to grow as the proportion of seniors in the population increases.
- The ultimate violent threat to Toronto is nuclear war. A one megaton nuclear strike would kill 750,000 people in Metro Toronto immediately, and severely injure more than a million others.

Violence and the portrayal of violence are inherent in much of society. Sources of violence include: rigid sexual stereotypes, intolerance of gay men and lesbians, and intolerance of people of colour, and those who appear to be different. While the Department is directly challenged by family violence, the challenge is to reduce the level of violence and the portrayal of violence generally in our community.

While there is little if anything that the Department can do directly that can prevent nuclear war, it remains a profound responsibility of public health to reveal the implications of "the final epidemic."

Physical Environment

3.3 The Environment of the City

The quality of the physical environment was one of the major challenges identified by Department staff and the community. Issues of concern include pollution and waste management, urban planning (including green space, urban and neighbourhood design and transportation) and concern with ecological and resource limits; the Ottawa Charter for Health Promotion includes ecological stability and resource sustainability among the prerequisites for health.

3.3.1 Pollution and Waste Management

We are faced with significant chemical and biological pollution of our air, water and food.

- While air quality in Toronto is generally considered to be satisfactory, some areas have problems, and vehicle emissions have been increasing; in Metro Toronto, these are the largest source of carbon monoxide, nitrogen oxides, lead and hydrocarbons and a significant source of sulphur dioxide and particulates.
- In June, July and August 1988, the City experienced 25 days of only moderate air quality (air quality index 32-49) and one day of poor air quality, in which the index reached 74; the picture was even worse in Metro Toronto as a whole.
- Though the quality of Toronto's drinking water is considered to be acceptable at present, Lake Ontario continues to be threatened by numerous sources of contaminants. These include local sources such as sewage treatment effluent, storm sewer overflows, sediments in Toronto Harbour, pollution in the Don and Humber rivers; and from remote sources such as the toxic chemicals leaking from dumpsites along the Niagara River.
- While average levels of PCBs, mirex, DDT and chlordane in Lake Ontario fish have decreased from 1976 levels, the 1987 Ministry of Environment Guide recommends that six species of fish found in the Toronto waterfront should not be eaten by women of childbearing age or children under 15.
- Routine sewage discharges of treated sewage are the largest source of contaminants to the waterfront; the Main Sewage Treatment Plant is the largest source of heavy metals, organics and phosphorus.
- Toronto's rivers and beaches have been plagued with bacterial contamination from sewers and the main rivers, and likely will be for years to come.
- Research by the Department for the International Joint Commission (1987), recently confirmed by an Ontario Environment Ministry Study, has revealed the presence of dioxin and PCBs in Ontario grown food.
- In 1986, the City produced roughly 300,000 tons of domestic solid waste, or over half a ton per person, a 13 percent increase since 1983; industrial and commercial wastes are roughly three times as much as domestic wastes, for a total of approximately two tons per person per year. Lack of suitable land-fill sites, concerns about incineration and other waste management problems will persist well into the next decade.

Other issues in toxic agent assessment and control in the Toronto ecosystem must be addressed, particularly the contamination of the food chain with air and water-borne chemicals including the use of pesticides. The responsible use and disposal of hazardous industrial and household materials must be ensured.

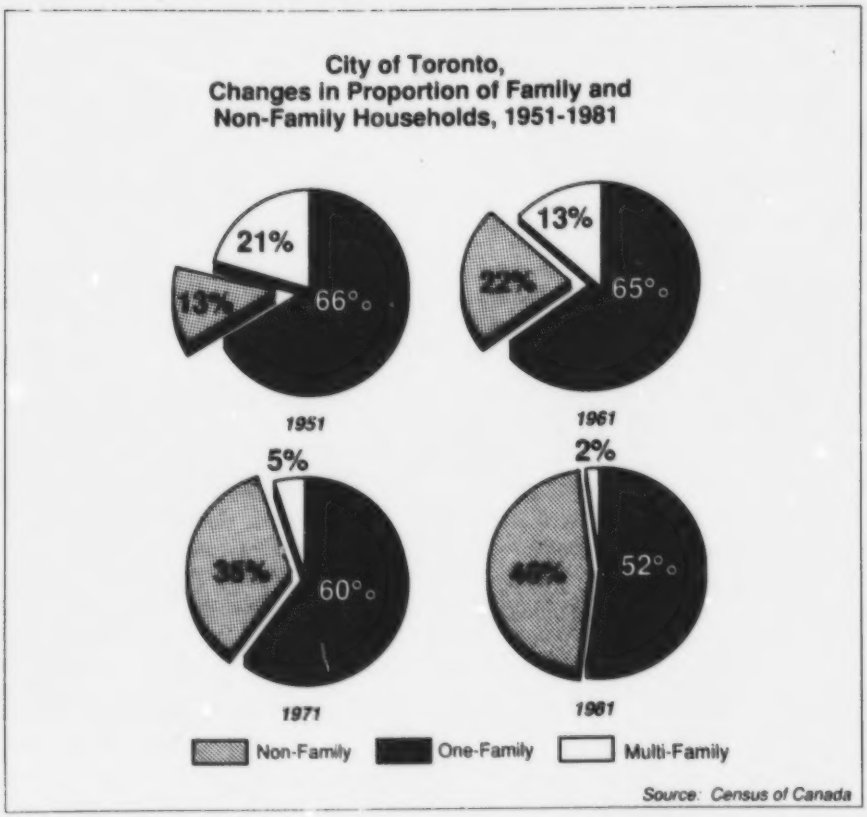
3.3.2 Urban Planning

Urban planning decisions present a number of challenges to people's health and well-being. The redevelopment of old and contaminated industrial sites, ongoing concerns about the interface between residential and industrial zones, the location or relocation of polluting industries, concerns with overdevelopment, the need to maintain human-scale neighbourhoods and to plan for healthful transportation options are just some of the issues.

- Although seven percent of the City's total area is taken up with public parks and open space (and another five percent is open or "vacant"), approximately one-third of the total area consists of road allowances and a further two percent is for parking.
- PCB contamination at the old Canadian General Electric (CGE) site has placed limits on its redevelopment potential and may have ruled out housing on the site, while lead contamination from smelters in the City has been a major source of concern for years.
- Problems with lead, PCBs, noxious odours and local sources of soil contamination will continue, particularly as older industrial plants are decommissioned.
- Over 2.8 million square meters of office space has been committed or is actively proposed for the Central Area, enough for roughly 100,000 employees; in 1987, 373,000 people were employed in the Central Area, up 15.8 percent from 1981.
- Vehicle trips into the Central Area in the three hour morning peak period have increased 11.8 percent from 95,841 in 1977 to 107,183 in 1987; truck trips have increased 33.5 percent, from 10,295 to 13,743 (Figure 10). Numbers of vehicles entering the City daily increased 36 percent between 1970 and 1987.
- TTC proposals to replace trolleys on the Bay Street route with diesel buses have been opposed on the grounds that diesels will generate more pollution.
- A 1987 study found that over 18,000 trips involving dangerous goods are made daily on roads in the greater Toronto area.
- Approximately three to four percent of total rail freight traffic through the City consists of "dangerous" or "special dangerous" commodities; over 300,000 Toronto residents live close enough to the railways to be affected potentially by a "dangerous commodity" incident.
- Poorly designed housing developments can increase alienation and antisocial behaviour.

Assessment of the health implications of urban planning decisions is an important new role for public health and one in which the recently established Environmental Protection Office is pioneering. It is that the health effects of urban planning are taken seriously, and are assessed at an early stage of the process.

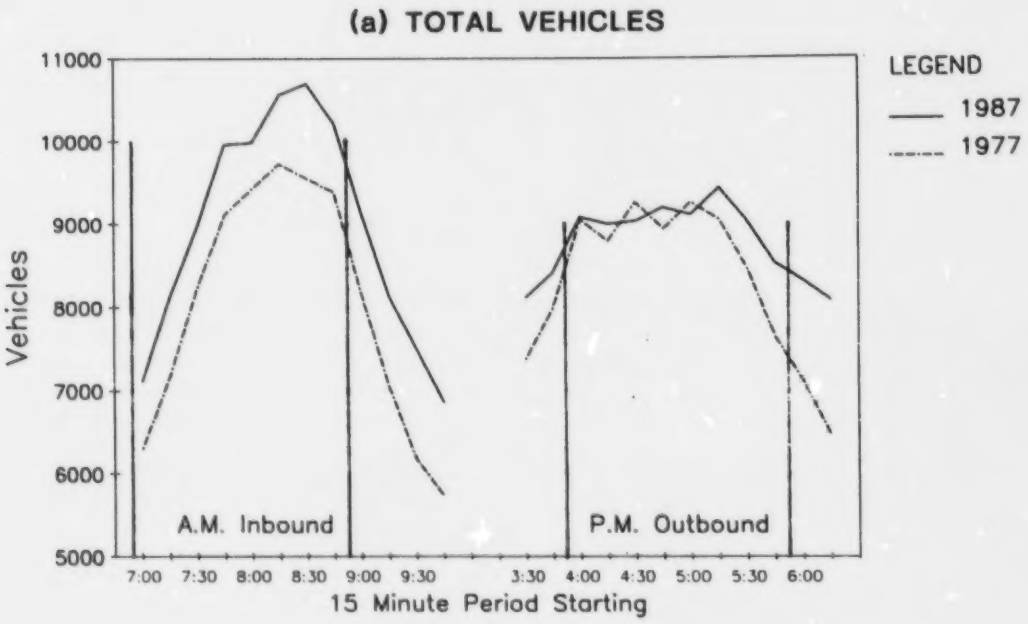
FIGURE 9



Source: Research Bulletin # 27, 1986
City of Toronto,
Planning and Development
Department

FIGURE 10

EXHIBIT 21: PEAK PERIOD COUNTS BY 15-MINUTE PERIOD AT CENTRAL AREA CORDON



Source: Central Area Monitoring Program: Second Annual Report Metropolitan Toronto Planning Department, June 1988.

3.3.3 Sustainability

As the recent report of the World Commission on Environment and Development (Brundtland Report) and the Report of the National Task Force on Environment and Economy indicate, ecological stability and resource sustainability are threatened. These two reports, the latter of which has been endorsed by the First Ministers, also emphasize the global nature of environmental problems. Both reports indicate the need to switch our economic system and way of life to one that is sustainable in the long term, and that takes into account ecological constraints and the needs of future generations, including of course their health.

These concerns, although global, directly affect health in Toronto, for example, the potential effect of stratospheric ozone layer destruction on skin cancer rates. The City, like all urban areas, directly contributes to the problems through its use of energy and other resources, through carbon dioxide build-up (the main cause of the "greenhouse effect"), acid rain and other toxic waste.

Chemical contaminants in drinking water, pesticides and other residues in food, and similar problems are not confined to Toronto, but are found in many other Great Lake cities. Clearly an ecosystem approach, involving all the communities in the Great Lakes ecosystem will be needed to resolve them.

The current garbage crisis poses a direct threat to health. The solutions to this health challenge lie in such approaches as reduction, reuse and recycling. At present, only one percent of solid waste in Metro is recycled, though a City-wide program for curbside collection of household recyclables is about to start. Such resource conservation strategies are health enhancing, both in the immediate sense of reducing the pollution that so often results from disposal methods and in the long term, in the sense that future generations will have the resources they need for life and health.

In a global sense, a shift to more energy and resource conservation will be necessary for long-term health, and even for our survival.

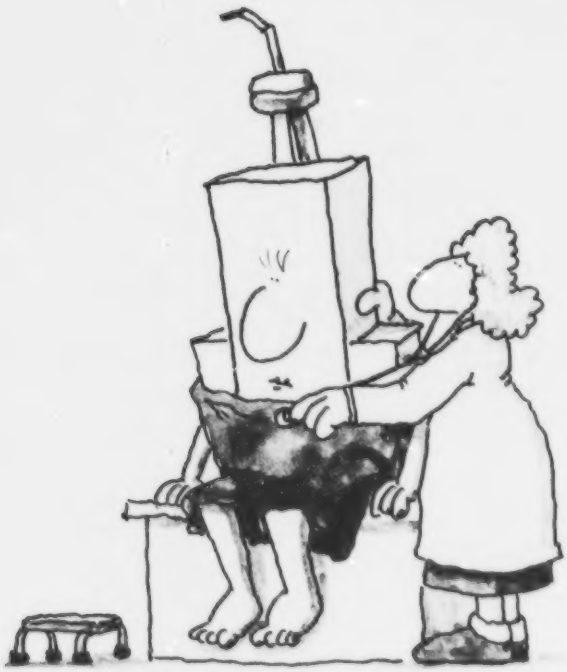
3.4 The Community's Health

While our health on the whole has improved in recent years, a number of major health problems still exist, and new ones have emerged. Perhaps the most dramatic health challenge is the inequalities in health that we find in our society. Cardiovascular disease continues to be the major cause of death, while substance abuse (tobacco, alcohol and drugs) contributes among other things to heart disease, lung and other cancers, liver disease, accidents, mental health problems and, in the case of injection drug use, communicable diseases such as AIDS and Hepatitis B. The emergence of AIDS has been a major challenge to public health, and will continue to be for years to come. Mental health problems are a challenge because of their widespread nature, complex and poorly understood origins and the deficiencies of our mental health care system.

3.4.1 Inequalities in Health

Serious inequities with a major impact on health exist in Toronto, as elsewhere in Canada and other industrialized nations.

- In Canada, life expectancy for males in the 20 percent of the population with the lowest income is 6.3 years lower than for those in the highest income quintile.
- Females from the highest income quintile have 2.8 years greater life expectancy than females from the lowest income quintile.



The Community's Health

- People in the lowest income group have a shorter life expectancy, and are likely to experience more years of disability.
  - The highest-income males in Canada by comparison can expect 14.3 more years of disability-free life.
  - High-income females can expect 7.6 more years free of disability.
- The average age of death was 7.6 years greater for women than for men in the City of Toronto in 1987; men lost more than twice as many potential years of life as did women.
- While there was no significant difference between men and women in self-assessed health status in the 1983 Toronto Community Health Survey, women were more likely than men to have been hospitalized, consulted a physician, taken medications and report activity limitation.
- Women in Toronto in 1983 smoked less than men (32 percent vs 41 percent), fewer were heavy drinkers (5 percent vs 14 percent) and more had annual blood pressure check-ups (84 percent vs 72 percent) and visited their dentist (67 percent vs 53 percent).
- In Canada in 1978, women could expect 12.2 years of disability in their lives, compared to 9.7 years for men.
- Infant and childhood mortality in the lowest income group is approximately twice that in the highest income group in Canada.
- A recent analysis of health status differences in Ontario children concluded that those in lower socio-economic classes were much more likely to have chronic health problems and functional limitations.
- Native people in Canada have mortality rates two to four times the rate for non-Natives, and higher rates of the major causes of disability, as well as mental illness and drug and alcohol abuse. Native people migrating to Toronto bring health problems with them; these problems are often accelerated by the stress of adapting to urban living and by difficulties in accessing health services.
- In Toronto, comparison of mortality rates from 1979 to 1983 indicates:
  - The burden of mortality among those in the poorest census tracts appears to be greater than expected for all categories of death except cancer.
- The Department's 1983 Community Health Survey found:
  - among those earning less than $20,000, only 74 percent reported they were in excellent or good health, while 89 percent of those earning more than $30,000 reported excellent or good health; heart disease, hypertension and diabetes were more prevalent in the lowest income groups and almost twice as many earning less than $20,000 report difficulty in routine physical activity compared to those earning over $20,000 (28 percent vs 15.6 percent).
  - compared to those earning over $50,000, those earning under $10,000 reported rarely or never feeling loved or wanted four times as often (20 percent vs 5 percent); sometimes or often feeling isolated and lonely over three times as often (41 percent vs 12 percent); and not feeling too happy nine times as often (19 percent vs 2 percent).

Every effort must be made to reduce these inequalities in health by addressing the needs of those affected. The reduction in inequities to access the basic prerequisites for good health such as food, shelter, work, education and income, require broad-based social and political initiatives beyond the realm of public health services. These prerequisities for good health need to be considered as challenges for the local community and urban government together.

3.4.2 Cardiovascular Disease

Cardiovascular disease is still the leading cause of death in Toronto, accounting for 1,869 out of 5,109 deaths in 1986. The dramatic decline in cardiovascular disease mortality in the past decade is reflected in the fact that in 1976, 2,642 out of 5,762 deaths were from cardiovascular disease.

- Since cardiovascular disease is the major cause of death, its decline has contributed significantly to the 28 percent decline in the overall standardized mortality rate in that same period.
- Mortality rates for ischaemic heart disease were significantly lower in Toronto than elsewhere in Ontario in 1983.

Nonetheless, cardiovascular disease continues to be a major killer. Tackling heart disease requires initiatives in nutrition, smoking, fitness, stress management or alleviation, control of high blood pressure, diagnosis, treatment and rehabilitation. Clearly, a comprehensive and long-range strategy is called for, with a particular emphasis on the low-technology approaches that are the major factor in reducing heart disease mortality.

3.4.3 Cancer

While deaths from heart disease have dramatically declined, deaths from cancer have not. In 1976, 1,304 Toronto residents died from cancer; in 1986, the number was 1,325.

- The standardized mortality rate for all forms of cancer has decreased 12 percent from 173 per 100,000 in 1976 to 152 per 100,000 in 1986.
- While male lung cancer mortality rates decreased 24 percent in that period, female lung cancer mortality rates zoomed by nearly 75 percent and will continue to increase for many years; tobacco is a factor in 25 percent to 40 percent of all cancer deaths.
- While the five year survival rates for some forms of cancer (such as some leukemias and lymphomas) have increased dramatically, in others (such as breast cancer, stomach cancer and colon cancer) there has been little or no improvement.
- There is evidence to suggest that up to one-third of cancer may be linked to diet and carcinogens in food, particularly in fats. Dietary fats are implicated in breast and colon cancer and associated with several other forms of cancer; as a consequence, a low fat, high fibre diet with plenty of fresh fruit and vegetables has been recommended by the Cancer Society.

As heart disease declines, cancer assumes a greater significance. Given what we know about the importance of environmental, social and behavioural factors in the development of cancer and the relative failure of the therapeutic approach, it will be important to develop a comprehensive cancer prevention strategy.

3.4.4 Substance Use and Abuse

As a society we indulge in a great deal of substance abuse, by which is meant the use of any substance

> "in a manner that deviates from the approved medical or social patterns within a given culture".
>
> Jaffe, 1980

Four substances are of particular concern; tobacco, alcohol, prescription, over-the-counter drugs and illegal drugs. While the latter tends to make headlines, abuse in the other three categories is much more widespread and the health, social and economic consequences in many respects are greater.

- Tobacco smoking contributes to over 35,000 deaths annually in Canada, and approximately 750 deaths in the City of Toronto; it causes the largest number of preventable deaths in our community.
- The 1983 Toronto Community Health Survey found that 36 percent of all Toronto residents reported smoking tobacco.
- It is estimated that over 400 deaths annually in Toronto, one in every eleven deaths, are related to alcohol. In addition, alcohol contributes to one in five hospital days, is a major factor in motor vehicle and other accidents, and a variety of other health problems, including some forms of cancer.
- Nine percent of Toronto residents reported in the 1983 Community Health Survey that they consumed more than 14 drinks weekly, a level that constitutes a major health risk. In a 1987 survey of Ontario students (grades 7 to 13) 68 percent report using alcohol at least once in the past year. This is lower than the 76 percent who reported use in 1977.
- Use and abuse of prescription and over-the-counter drugs are widespread. Forty percent of respondents in the 1983 Toronto Community Health Survey reported taking at least one medication (excluding vitamins and minerals) in the previous two days.
- In 1987, nearly one in ten women in Ontario reported using tranquilizers in the past 12 months, compared to fewer than one in twenty men; this is an improvement on the nearly one in six women and one in 11 men in 1977. Use of tranquilizers in Metro appears to be somewhat lower than the provincial average.
- While illegal drug use on the whole does not seem to be growing, use of cocaine and "crack" has increased. In 1987, 13 percent of the population of Metro Toronto reported using marijuana or hashish in the previous year compared to 17 percent in 1984. In a survey of adults in 1987, 14 percent of those in the 18 to 29 age group reported ever having used cocaine, an increase from seven percent in 1984. Only 4.5 percent of those age 30 to 49 reported having ever used cocaine.
- In 1987, 13 percent of Metro children in grades 7 to 13 reported using cannabis at least once in the previous year; this compares to 18 percent in Eastern and Northern Ontario in 1987, and 20 percent in Metro in 1985. The use of cocaine by Metro students has not changed significantly since 1981 and overall the percentage of students reporting illegal use of substances is generally lower in 1987 than in 1977.
- A recent survey at Sunnybrook Medical Centre Trauma Unit suggests that drugs may be as important a factor as alcohol in serious motor vehicle accidents.
- The Metro Toronto Police reported that in 1987 the quantity of heroin seized was up 557 percent over 1986, LSD up 257 percent, marijuana up 110 percent and cocaine up 24 percent.

Use of illegal drugs is far less widespread than the abuse of alcohol and results in fewer deaths and less disease and injury. It is of concern because of the association between an expensive drug habit and the criminal activities that may be pursued to support it. There is also a concern about the spread of AIDS resulting from shared needle use. Alcohol abuse and smoking remain our most significant substance abuse problems, while abuse of prescription and over-the-counter drugs is an important aspect of our society's "drug culture".

3.4.5 Mental Health Problems

Mental health problems are a major cause of impaired well-being, hospitalization, and disability, as well as death by suicide or through alcohol or drug abuse. This is shown at its most extreme in high suicide rates.

- Deaths from suicide declined by one-third between 1976 and 1986, (from 122 deaths to 81 deaths; the crude mortality rate in Toronto was much higher than in Ontario as a whole in 1976, but was only slightly higher in 1986. Nonetheless, in 1986 suicide was the fourth largest cause of potential years of life lost in both sexes in Toronto.
- In 1982/3, hospitalization for mental health problems accounted for nearly 25 percent of all patient days in all Canadian hospitals.
- The proportion of patient days in general hospitals caused by psychiatric problems rose from six percent in 1971 to ten percent in 1983.
- As many as one in six people will receive some form of psychiatric help during their lifetime. In addition, the ongoing health, housing, and other social problems of discharged psychiatric patients remain major challenges to the City.
- Eight percent of Toronto residents reported using central nervous system medications in the previous 48 hours in the 1983 Community Health Survey.

Many of the mental health problems in our community are difficult to identify. Certainly there are problems associated with urban living and change. There are others associated with life crises, search for identity and sexual identity, broken families or absence of family support and loss of a homeland. In spite of the enormity of mental health issues in our community we have little research to suggest how to improve mental health, too few studies, too inadequate a system, too few staff - in short, mental health has not been given the priority it deserves. What we do know suggests that social interconnectedness and a sense of control over the resources necessary for health are important to good mental health, and this suggests that a community development approach is called for.

3.4.6 AIDS

AIDS has become the leading cause of death among Toronto males aged 25 to 44. In 1987 it also became the third leading cause of potential years of life lost in males. The first case of AIDS in the City of Toronto was reported to the Department in 1982. Between that time and the end of August 1988, 425 cases of AIDS were reported, along with 2,940 positive HIV antibody test reports. Sixty-four percent of people diagnosed with AIDS are between the age of 20 and 39, and 97 percent are gay or bisexual males. Approximately 63 percent of those diagnosed since 1982 are deceased.

If the current trend continues, the City can expect about 600 cases by the end of 1989. There is an increase in infection among the young, females and injection drug users, indicating the predicted spread of the disease beyond gay men.

Toronto has the highest AIDS rate/million population (594.5) of any major metropolitan area in Canada. As of February 1988, the City had 58 percent of all cases in Ontario and 82 percent of all cases in Metro Toronto.

3.4.7 Trauma

The mortality rate from accidents, poisoning and violence (including suicide and homicide) declined 48 percent between 1976 and 1986.

- Accidents accounted for 146 deaths in Toronto in 1987, (down from 201 in 1985) and were the fourth highest cause of potential years of life lost; among males aged 15 to 34, accidents were the second highest cause of death, principally due to motor vehicle accidents.
- Half of all accidental deaths in 1987 resulted from falls. Seniors were particularly hard hit, with 43 percent of all accidental deaths resulting from falls among those 65 and over. Ninety-seven percent of deaths due to falls were in those aged 55 and over, most of which occurred at home or in residential institutions. In addition to deaths, falls are a major contribution to hospitalization and resulting disability.
- While the motor vehicle accident rate in the City is about the same as for the province, the mortality rate of City residents is much lower. This probably reflects the lower traffic speeds in the City, compared to highway speeds, and the extensive use of public transit. Road accidents resulting in injury increased from 14,607 in Metro Toronto in 1983 to 19,335 in 1987, while the number of persons injured increased from 19,966 in 1983 to 27,713 in 1987, a 38 percent increase.
- Victims of serious traffic accidents rarely return to normal lives; one-third of survivors need extensive rehabilitation and 20 percent need some form of home care.
- Alcohol was involved in 46 percent of all driver fatalities in 1986 in Ontario. In a recent study, 37 percent of motor vehicle accident victims admitted to a Metro trauma unit had high blood alcohol levels.

3.5 The Community's Health Care System

While it is true that Ontario has one of the best health care systems in the world, and medicare is the most comprehensive social program in the country, that very success has caused some problems. The overemphasis on the medical model and the institutional basis of the system have resulted in a very expensive system. As Murray Elston, former Ontario Minister of Health, noted in a speech to the Canadian Club in Toronto in September 1986 "while a one-third hike in real health care spending is projected, no one seriously believes we are going to be one-third healthier as a result".

The major challenges are to achieve a more balanced and community-based system of health care with more collaboration and coordination both within the health care system and between the health care system and other human services; and to shift resources and emphasis to health promotion and disease prevention.

3.5.1 A Community-Based Health Care System

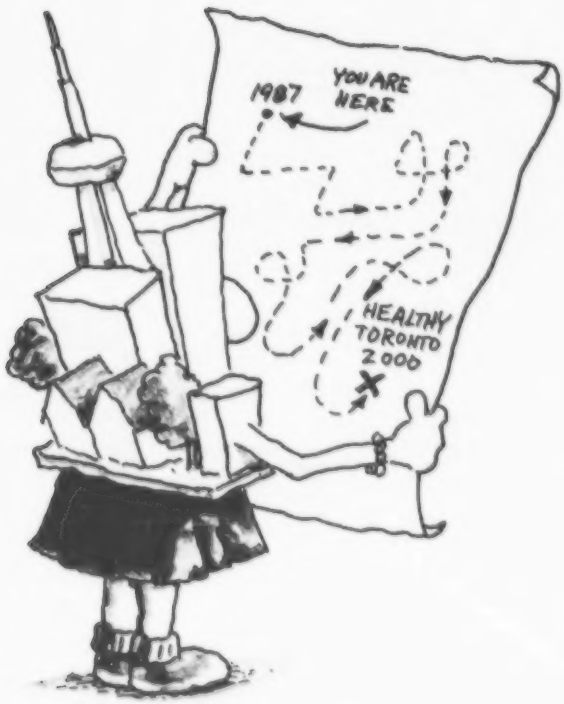
Numerous reports over the past decade, most recently the report of the Ontario Health Review Panel, have called for the creation of a comprehensive community-based health care system and for better coordination within the existing system.

- A recent study for the Canadian Medical Association indicates that unless our pattern of institutionalization and services change, the aging of the population will result in a need for approximately 50 percent more hospital and long-term care beds by the year 2000.
- The same report, however, concluded that the system was not underfunded but rather that the funds are misallocated.

A comprehensive community-based health care system would cover all aspects of health care from birth to death including such "innovations" as community health centres, birth centres, day hospitals, daycare, home care, community support services and hospices. At the same time, we are facing a growing demand from Metro Toronto hospitals for capital funding for renovations and expansion. We have to seriously question whether we are getting the biggest bang for our health buck, or whether our health dollars are being inappropriately used, as in the over-prescription of medications.

3.5.2 Health Promotion

The need to shift our attention and efforts towards health promotion and disease prevention is the focus of this Report.



Towards Healthy Toronto 2000

4. A Healthy City Initiative

With an understanding of the historical development of public health, the work of the Department of Public Health, recognition of the major challenges to Toronto's health and a clear conceptual framework, we are now in a position to propose a health agenda for Toronto which we believe will make Toronto the healthiest city possible.

4.1 Overview of the Healthy City Initiative

A healthy city is not simply one whose population enjoys a high health status, nor is it one which has a healthy environment, though both are important results of a "healthy city" policy approach. Rather, it is one that recognizes the challenges to health and mobilizes its resources to meet them. It is, as the World Health Organization's background paper on healthy cities puts it:

> "... one that is continually developing those public policies and creating those physical and social environments which enable its people to mutually support each other in carrying out all the functions of life and achieving their full potential."

Clearly, this is a task that calls for health to be high on the agenda of all sectors of the community and for an ongoing process of mobilization for health.

Of course, we cannot direct the actions of the community, nor even of City government. What we can do is propose to City Council and to the community, a strategy for a Healthy City Initiative — together with an outline of the Department of Public Health's contribution to that initiative — and then work together to make Toronto more healthy.

The most important thing to stress at the outset is that this consists of both a health agenda for Toronto, and a healthy city strategy for the Department of Public Health. This is the most fundamental difference between this report and its predecessor - ***Public Health in the 1980's*** - which focused its attention upon the Department of Public Health.

The first component of the initiative is ***a health agenda for Toronto*** which addresses the basic prerequisites for good health (food, shelter, work, education, income, peace, ecological stability, resource sustainability, equity and social justice) and four of the seven proposed health goals for Ontario, namely:

- reduce inequities in health opportunities;
- establish environments supportive of health;
- enable people to achieve their health potential;
- establish public policies for health.

This calls for the development by City Council of healthy public policies that will reduce inequities in health opportunities by ensuring that the people of Toronto have access to the basic prerequisites for health and that will ensure that we create physical and social environments supportive of health. Thus we propose the establishment of the structures and processes needed to ensure that health is high on the agenda: a Healthy City Office and a City Healthy Public Policy Committee. This agenda also calls for community empowerment to be a major concern of local government, so that individuals and communities can increase control over and improve their health.

Within the overall Healthy City Initiative, it is appropriate that the Department of Public Health play a lead role in two areas: in food, because of the Department's responsibilities with respect to nutrition and, in environmental protection and development of a sustainable community strategy, through the Environmental Protection Office.

The second component of the initiative is a *Healthy City Strategy for the Department of Public Health* which addresses the Department's role not only in contributing to these four proposed Ontario health goals but in specifically meeting the remaining three goals:

- increase health expectancy;
- develop personal skills for health;
- provide health services supportive of health.

The Department will meet those provincial goals, and carry out its own mission and provincially mandated programs through a wide range of programs organized in four goal related program areas:

- community preventive health programs (programs directed at specific lifecycle stages, community locations and health problems) that increase health expectancy;
- community health protection programs which will create healthful environments and protect people from health hazards;
- community health promotion programs that help people acquire skills to achieve their health potential;
- community health planning programs that collect and provide health data.

Each of the Department programs will reflect the Department's three priority concerns:

1. To reduce inequalities in health.
2. To meet diverse cultural needs.
3. To empower individuals and communities.

At the same time, the Department must pursue its fifth goal of supporting the Healthy City Initiative. To do so it must actively propose healthy public policies and work with other City departments and the community to ensure that the health agenda for Toronto is developed and implemented.

The relationship between the challenges to the health of Toronto and the elements of the proposed Healthy City Initiative is shown in Table 1.

Table 1

Challenges and Responses

	Challenges	Responses
3.1.1	An Aging Population	Healthy Seniors (see 4.3.1): - See also housing and health, urban planning and transport planning, community empowerment and support, a community-based health services system, dental health.
3.1.2	A Multicultural Community	The need for the Department to address multicultural concerns in *all* of its programs is one of three priority concerns (see 1.7): - See also community development in a multicultural society, community empowerment and support, promoting mental health, healthy eating, health communications.
3.1.3	Changing Family Structures	Healthy Parents/Healthy Children (4.3.1): - See also, income work and health, community support, women, power and health, healthy seniors, health at school, health at work, communicable disease control, community development in a multicultural society.
3.2.1	Housing	Healthy Housing Policy (4.2.1): - See also income, work and health, urban planning for health, community sanitation and environmental protection.
3.2.2	Food	A Food Policy Council (Food For Health, 4.2.1) And Healthy Eating (4.3.1): - See also heart health, cancer prevention, dental health, community sanitation and environmental protection.
3.2.3	Work	Income, Work And Health (4.2.1) And Health At Work (4.3.1): - See also promoting mental health, community sanitation and environmental protection.

3.2.4	Education	Education For Health (4.2.1), Health At School (4.3.1) And Health Education (4.3.3): - See also healthy parents/healthy children, promoting mental health, heart health, cancer prevention, preventing substance abuse, healthy eating, dental health, healthy sexuality.
3.2.5	Income Distribution	Income, Work And Health (4.2.1): - See also housing and health, community empowerment.
3.2.6	Safety, Security and Peace	A Safe City (4.2.3): - See also urban planning for health.
3.3.1	Pollution and Waste Management	Urban Planning for Health (4.2.2), Community Sanitation and Environmental Protection (4.3.2): - See also a sustainable community.
3.3.2	Urban Planning	Urban Planning For Health (4.2.2): - See also transport planning for health, community sanitation and environmental protection.
3.3.3	Sustainability	A Sustainable Community (4.2.2): - See also urban planning for health, transport planning for health, community sanitation and environmental protection.
3.4.1	Inequalities in Health	The need to address inequalities in health in all the Department's programs was one of the three priority concerns identified in this report: - See also housing and health, food for health, income, work and health, education for health, community empowerment, community support, community development in a multicultural society.
3.4.2	Heart Disease	Heart Health (4.3.1): - See also cancer prevention, preventing substance abuse, healthy eating.
3.4.3	Cancer	Cancer Prevention (4.3.1): - See also heart health, preventing substance abuse, health at work, community sanitation and environmental protection.

3.4.4	Substance Abuse	Preventing Substance Abuse (4.3.1)
3.4.5	Mental Health	Promoting Mental Health (4.3.1) - See also community empowerment, community support, a safe city, women, power and health, healthy parents/healthy children, healthy seniors, health at school, health at work, preventing substance abuse, healthy sexuality.
3.4.6	AIDS	Communicable Disease Control (4.3.2), Healthy Sexuality (4.3.1).
3.4.7	Trauma	Accident Prevention (4.2.2) - See also transport planning for health.
3.5.1	A Community-Based Health Care System	Advocate for a Community-Based Health Services System (4.2.4).
3.5.2	Health Promotion	This Report.

4.2 A Health Agenda for Toronto

The City's health agenda must address the inequities in health opportunities that still affect a significant proportion of our population. City policies must address the relationship between housing and health, food and health, income and health, work and health and education and health.

In addition, the City must work to create physical environments that support health through good urban planning and new approaches to ecosystem management, and social environments that enable people to achieve their health potential through facilitating community empowerment, (particularly among women), strengthening community supports and creating a safe city. Finally, the City must advocate for an expanded community-based health services system.

Of course, the City cannot do all of these things alone. While it can demonstrate leadership and set an example, it also must play a role as an enabler of community action and a partner with other sectors of our community in making Toronto the healthiest city possible.

If the City is to develop and implement its health agenda effectively, the necessary political and staff structure must be established.

Recommendations:

2. City Council establish a Healthy Public Policy Committee to audit, monitor and coordinate the work of the City standing committees and departments with respect to enhancing the City's health and environment. This Committee would:

   - ensure that City policies are consistent with the proposed Framework for Action.
   - establish long-term health goals, objectives and targets for the City and a five-year plan for implementing the Healthy City Initiative;
   - develop and oversee the process of community involvement at all levels and in all sectors of the City in development and implementation of the Healthy City Initiative;
   - ensure that accessibility to City decision-making and to City services that affect health is open to the multicultural community;
   - oversee the work of the proposed Inter-departmental Healthy City Workgroup and the proposed Healthy City Office;
   - link with the Canadian Healthy Communities project, the World Health Organization (WHO) Healthy Cities project and with other Healthy City/Healthy Community projects in Canada.

3. City Council establish a Healthy City Office to be located in an appropriate City department. This Office would be responsible for developing the City-wide Healthy City Initiative as outlined in this Report under the direction of the proposed Inter-departmental Healthy City Workgroup and the proposed City Healthy Public Policy Committee.

4. City Council establish an Inter-departmental Healthy City Workgroup to coordinate the activities of the various departments involved in the City-wide Healthy City Initiative; the Workgroup would also oversee the work of the proposed Healthy City Office and would provide advice and consultation to the proposed City Healthy Public Policy Committee.

4.2.1 Reduce Inequities in Health Opportunities in Toronto

> "When inequality becomes too great, the idea of community becomes impossible."
>
> Raymond Aron

No city can claim to be healthy when some of its citizens are hungry, homeless or living in dreadful housing, unemployed, illiterate, and in deep poverty. Yet, as we have seen, there are many in Toronto who experience these conditions daily.

If the citizens of Toronto are to have equitable opportunities to achieve good health, they must all have access to adequate housing, healthy food, an adequate income, work and education.

Thus, the first step in the City-wide Healthy City Initiative must be to do all in its power to reduce these inequities and to advocate for other levels of government to do the same.

Housing and Health

The current housing crisis in Toronto, reflected in homelessness, poor quality or unaffordable housing, is having an adverse impact on people's health. The Department of Public Health has been actively involved in the housing issue since its first report on the public health implications of the affordable housing crisis in 1984.

Among the homeless and hard-to-house are the 5,000 to 20,000 street people - those of "no fixed address". A high proportion of these are deinstitutionalized psychiatric patients, who may have a history of disruptive behaviour, which may result in exclusion from supportive housing or hostels. Others who may have housing problems include: those with physical disabilities, assaulted women and their children, the elderly, street youth, persons with AIDS, low income and single parent families and refugees.

The health effects of homelessness, while difficult to separate from the often associated effects of poverty, include: cold injury (hypothermia and frostbite), chronic heart and lung diseases, tuberculosis, skin problems, nutritional disorders, sleep deprivation, infectious diseases, children's mental health disorders, adult psychiatric disorders, chronic stress, and the exacerbation of the health problems of street people (Report of the Inquiry into the Effects of Homelessness on Health.)

The cost of housing also has an adverse effect on health; when housing costs are high, those on low incomes have less disposable income. This is stressful in itself and may lead to a reliance on food banks. The impact of speculation on housing costs is a particular concern, and one which should be controlled.

In addition to the health problems posed by homelessness, the effects upon health of poor quality housing and of badly designed housing are only too well known. Poor quality housing may be dirty, dangerous, damp and in other ways hazardous to health. Strong and effective enforcement of building codes should ensure that such conditions do not exist. We know that when affordable housing is in short supply, such problems do indeed exist, and tenants are reluctant to complain.

Poor housing design, exemplified by the massive and hostile housing estates in Britain, has been shown to have very adverse affects upon social behaviour, providing the opportunity and often the incentive for vandalism and violence. While Toronto is fortunate in not having developed public housing on quite the scale or with the failures that we see in Britain, we can learn and should apply one of the lessons: occupant control of housing is beneficial. By occupant control, we mean ownership, or collective/cooperative ownership or collective control of rental housing. Not only is this a form of empowerment, it is also an important means of improving social conditions and social behaviour.

A final important aspect of housing and health, from the perspective of the City as a whole, is the need to provide housing suitable for families with young children, to ensure that the City remains attractive to young families, and a place for children. A city without children would be a very unhealthy city indeed!

Recommendation:

5. City Council, through the proposed Healthy Public Policy Committee and the Commissioner of Housing, establish a Policy to complement and, where appropriate, reorient existing housing policy. The Policy should have the following objectives:

   - there will be no need for anyone to be homeless in Toronto;
   - while temporary hostel accommodation might be necessary from time to time, permanent housing will be available for all who need it;
   - appropriate and affordable housing will be available for low income families and for families with children to ensure a "healthy" social mix in the City;
   - a full range of supportive housing options will be available for senior citizens, and for those with physical and mental disabilities that would enable them to remain within the community;
   - emergency hostels and shelters will be available for assaulted women and their children, street youths and others in urgent need of shelter;
   - occupant control of housing will be strengthened;
   - speculation in housing will be controlled to help to keep prices down;
   - all housing will meet minimum health standards.

Food for Health

The absence of food, in its most extreme, leads to starvation; in the less extreme forms that we might expect to see in Toronto, it has a variety of less dramatic but nonetheless serious health effects.

The issue of food availability includes whether it is affordable for families at or below the poverty line (particularly when housing is scarce and expensive, consuming a high proportion of their income) and whether they have access to food outlets. This may be a problem for families in the inner city, where food outlets are often fewer and prices higher, for housebound seniors and those with disabilities.

Food should be safe and nutritious. (These aspects are dealt with in the section on the Department's healthy city strategy.)

For many in Toronto today, the solution to unavailable or unaffordable food has been food banks. While this indicates a laudable, humane and charitable response from thousands of our citizens, this is an inadequate and band-aid approach. Furthermore, this represents an abdication of societal and government responsibility for people's basic well-being.

One response to the food crisis has been the development of community gardens (such as the one at Regent Park) that also serve as a focus for community organization around food issues. While there are sometimes concerns with soil pollution, the potential exists for substantial food production in the City, and this should be further explored.

Two final concerns related to food are the issues of sustainability and of preservation of agricultural land. We are facing a waste management crisis and depletion of the ozone layer, both of which are related in part to the packaging used for food. We have to look at ways in which the City can encourage less packaging and consider by-laws to prohibit the

use of packaging made with chlorofluorocarbons (CFCs). We also have to learn to harvest rather than mine the soil, and to ensure that there is productive agricultural land for future generations. One way to do this is to encourage a low meat diet, which requires less land per person.

This range of issues requires a broad food policy response. While it is true that the federal and provincial governments play an important role, there is nonetheless scope for municipal initiatives. The example of the London Food Commission, and the development of a Food Policy Council in Knoxville, Tennessee, provide us with an indication of what can be achieved.

With these precedents in mind, and with the evidence of food banks and nutrition-related health problems only too obvious in our City, it is time that City Council established a Food Council to develop and implement a "Food and Health Policy" for Toronto.

While a food policy and a Food Council are matters that involve a number of City departments, as well as the community and the business sector, the Department of Public Health's current responsibilities in the area of nutrition make it the logical lead Department.

Recommendation:

6. City Council, through the proposed Healthy Public Policy Committee and the Medical Officer of Health, establish a Food Policy Council with representation from City Council, the private business sector, churches, community groups, nutritionists, environmentalists and others involved in food issues. The Food Policy Council should work to achieve the following objectives.

   - there will be no hungry people in Toronto;
   - there will be no need for food banks in Toronto;
   - an adequate, safe and nutritious food supply will be available to all citizens;
   - accessible food outlets will be within reach of all citizens;
   - Toronto citizens will be fully informed about the nutritional quality of the foods they consume;
   - food-related actiwities which degrade the natural environment and waste scarce resources needed for food production and distribution will be minimized.

7. The Department of Public Health play a lead role in the development of the City Food Policy and provide staff support to the proposed Food Policy Council.

Income, Work and Health

We know that inadequate income is related to inadequate housing, diet and poor health. We also know that work plays an important social role in people's lives, and that unemployment has an impact on both body and soul. We are not concerned here so much with the quality of the work experience, and of ways of reducing hazards and improving health at work - these are dealt with in the section on the Department's strategy for health at work. What we are concerned with is the need to ensure that all those who wish to work can work, and that their work provides them with an adequate income. However, it must not be forgotten that the work itself should be inherently healthy and promotive of good health. This means that the City has to be concerned with an economic development strategy that provides an adequate number of jobs - but jobs that pay a decent living wage and are healthful.

While this is not within the jurisdiction of the Department of Public Health, it is clearly a concern. The City needs an economic development strategy which ensures that everyone who wants it has meaningful healthy work that provides an adequate income and, at the same time, ensures that economic development is environmentally sustainable, as we discuss later. At the same time, the City must advocate for a minimum wage that ensures an adequate income (certainly not below the poverty line, and not lower than the income from social assistance), and for a social "safety net" (unemployment insurance, welfare, etc.) that similarly meets the income needs of those without work while providing them with assistance in reentering the work force (such as job training, employment counselling, daycare and other programs); in short a system that provides a hand-up rather than a hand-out, that encourages independence and self-reliance on the one hand, and interdependence and mutual support on the other, while discouraging dependence and loss of autonomy.

Recommendations:

8. City Council develop an economic development strategy that will ensure the availability of healthful work that is environmentally sustainable and provides an adequate income.

9. The City advocate for minimum wage and social assistance levels that will ensure everyone in the City receives an income adequate for good health.

10. City Council advocate for a supportive employment/reemployment assistance program that includes training/retraining, job search counselling and support services, such as daycare, for those seeking to reenter the work force.

Education for Health

People who have difficulty reading and writing in our society are not only at a distinct disadvantage in obtaining adequate employment, they are also directly at risk. Those working with such people, such as Frontier College, describe the health hazards that come from being unable to read; the woman who picks up a generic spray-can of pesticide, in mistake for a generic spray-can of vegetable oil, the man who puts a tire repair kit into the oven thinking it is a fast food dinner, thus causing a fire; the family who cannot read the instructions on their medication; and the worker who cannot read the hazard warnings in the workplace and so on. We need a City strategy, developed in conjunction with the Ministry of Education, the Boards of Education, Frontier College and other adult literacy programs to ensure that all of our citizens can read and write. The Department of Public Health could assist in developing a health component for these programs. We could take a useful leaf from the book of the many developing nations who have undertaken effective and comprehensive adult literacy programs.

The Board of Education now has almost twice as many adults enrolled in their programs as children. Basic literacy courses for adults are vital to the enhancement of human potential and well-being, and the development of new skills necessary for our rapidly changing labour market.

Beyond the immediate and urgent need to be able to read and write, we need to ensure that everyone develops those life skills that are basic to citizenship. Not only do our children need personal skills for health, but personal skills that will enhance their ability to participate effectively in the community, to live in harmony with their fellow citizens and to mutually support each other throughout their lives. We also need to ensure that our children have a realistic understanding of the way our society works, the problems we face and how they can help solve those problems.

Finally, we need a comprehensive health education curriculum in our schools that helps our children to understand and make healthy life choices (including healthy sexuality choices) as they mature. Such a curriculum should be mandatory.

Clearly, the Board of Education and the Department of Public Health need to work together to develop an effective and comprehensive school health education curriculum.

Recommendations:

11. City Council advocate to the Boards of Education the need for all students in both day school and continuing education programs to be functionally literate upon leaving school, to have mastered the skills that would empower them to participate actively in community life, and to have benefited from a comprehensive health education curriculum developed in consultation with the Ministry of Education.

12. The Department of Public Heal.h collaborate with the Boards of Education toward the development of a comprehensive health education curriculum and the development of a health component in adult literacy programs.

4.2.2 Create Physical Environments Supportive of Health

Issues related to the physical environment ranked higher in the responses to our discussion paper than did issues related to social inequities. The words "clean" and "green" were the most frequent used in describing an ideally healthy City. We have identified four broad areas in which the City must take action, namely urban planning, transport planning, accident prevention and a sustainable community strategy.

Urban Planning for Health

The physical form that Toronto takes has a number of important implications for health. The issues include land use planning, particularly the redevelopment of former industrial sites; the preservation and enhancement of green space; the preservation of neighbourhoods; the design of housing; physical accessibility and issues of density and crowding.

- The decommissioning of old industrial plants and the redevelopment of these sites may pose a number of hazards to health when they are contaminated with lead, PCBs and a variety of other potentially hazardous wastes. The City has already taken an important step in this area by establishing the Environmental Protection Office (EPO). The EPO may need additional resources in order to address these and related issues of environmental quality in the City, and to do so in a way that ensures community involvement in the process.

- Green space is very important to people, over and above the important role that vegetation plays as the "lungs" of the City. However, the green space that people need changes over time, and various cultural communities have different values and requirements. The preservation and enhancem:..t of green space remains an important task for the City.

- One of Toronto's great strengths is its neighbourhoods, which are perhaps the most important form of community in the City. Thus, neighbourhood preservation plays an important role in the strengthening and development of communities, and often provides an important focus for community organization. Again, the sense of community and neighbourhood emerged as a strong element in people's vision of an ideally healthy city, and it is clear that it contributes both to physical and, perhaps more importantly, social health and well-being.

- The physical design of housing has important implications not only for physical health but for social well-being. We have learned a great deal about this since the early and less successful days of development exemplified by, for example, Regent Park and other projects of its kind. It is important that these lessons continue to be applied in the development of new neighbourhoods such as St. Lawrence Square; this means, among other things, not having children and old people living high up in highrises, rejecting potential sites that encourage vandalism and violence and putting in design features that encourage neighbourliness and community building. It is particularly important that housing be designed to fit the needs of seniors, and that programs of retrofitting and accident-proofing be developed to modify existing housing stock to meet their needs.

- It should go without saying that the City should be accessible to the disabled, to seniors, and to mothers with young children. The City has a good record in this respect, but there is still much that could be done to improve access in a way that does not denigrate the disabled by requiring them to take backstairs or freight elevators.

- The further development of offices and housing in the downtown and proposals for intensification of commercial strips raises the issue of the health impacts of increased densities. The direct physical impacts are likely to result from increased vehicle emission and other problems resulting from higher traffic densities; the equally serious and less understood question concerns the effects of increased density upon mental health. This is not a simple matter - high density per se is not the issue, rather the issue is one of the perception of crowding, noise, lack of privacy and other problems, together with a concern about the effects of increased commuting on mental health and family life.

Recommendations:

13. City Council ensure that assessment of physical, mental and social impacts on health becomes a critical component of City of Toronto plan approvals.

14. The Department of Planning and Development and the Department of Public Health undertake a study of the impacts of increased density, including such issues as the health impact of commuting upon physical, mental and social well-being.

Transport Planning

Transport planning is, in some respects, an aspect of urban planning and is closely related to plans for redevelopment. However, the health implications of transport planning are of sufficient concern to merit being singled out, particularly since many of the transport planning decisions are not made by the City but by higher levels of government, including Metro and the province.

The issues concerned are those of reduction of vehicle emissions, the encouragement of public transit, pedestrian cyclist and driver safety, accessibility to public transit, and the impact of commuting on mental health and home life.

- There is evidence that vehicle emissions have increased of late, and will likely continue to increase as a consequence of further development in the downtown area. The City needs a strategy with specific targets to reduce vehicle emissions by a combination of limiting the number of vehicles downtown (including through the encouragement of public transit); better tuning of engines (particularly diesels), the elimination of leaded gasoline, the use of alternative fuels and other approaches.

- One important means of reducing the number of vehicles, and thus the emissions, is to improve public transit. Not only is public transit better for health because of fewer emissions, it is also better for health because of fewer accidents per passenger mile (particularly given the enviable safety record of the TTC). The City should thus be doing all in its power to encourage good, cheap and efficient public transit.
- Another way to reduce private vehicles is to encourage more people to cycle or walk. A concerted effort to improve the safety of cyclists in Toronto by physical separation of cyclists from motor vehicles will serve both to reduce accidents and vehicle emissions.
- The ability to move freely around the City was a common theme emerging from the vision workshops. This is particularly important for seniors, for mothers with young children, and for the disabled. For them, the TTC is often an important means of getting around, and to the extent it is physically inaccessible to them, it prevents them from participating fully in the life of the City and may even prevent them from carrying out relatively simple but important tasks such as food shopping, visits to health and social services. One important priority is the provision of escalators at all subway stations. It is important that there be at least one elevator or one ascending escalator, particularly for older people, since having to walk up stairs can present a real barrier.
- As commuting distances become longer and more crowded, and as streets become more jammed, frustration and tension rises. The impact of commuting on mental health and family life should be part of the study of the impact of increasing density on health already referred to.

Recommendations:

15. City Council develop and adopt a vehicle emissions reduction strategy which includes some or all of the following:
    - reduction of the number of vehicles on City streets;
    - encouragement of public transit;
    - program to ensure that engines are properly tuned;
    - advocacy for a program to encourage less polluting alternative fuels;
    - encouragement of walking and cycling as alternatives to driving.
16. City Council take steps to improve safety for cyclists, including the consideration of developing physically separated bicycle lanes/pathways.
17. City Council request the Toronto Transit Commission to provide escalators and/or elevators at all transit stations, and to ensure that there is always at least one ascending escalator or an elevator.

Accident Prevention

Preventing accidental deaths and injuries in Toronto requires two main approaches. The first must be to continue to emphasize the problem of drinking and driving and of unsafe driving habits. Good public transit contributes to safety by providing alternatives to driving; the need to improve safety for cyclists has already been mentioned.

A more important issue may be to address the problem of falls among seniors. A program to "accident proof" the homes of seniors and institutions housing seniors could be an important contribution. The program being developed in North Toronto to "accident proof" the homes of seniors, a project involving the Department of Buildings and Inspections, the Community Economic Development Program in the Department of Planning and Development, and the Department of Public Health, is an example of the sort of program that should be developed City-wide.

Recommendation:

18. City Council, through the Department of Buildings and Inspections develop a program to "accident proof" homes, (particularly the homes of seniors); other accident prevention programs should be developed through the proposed Healthy Public Policy Committee.

A Sustainable Community

Toronto's environmental problems cannot be considered in isolation. Pollution of Lake Ontario and contamination of the food chain are not local problems, but problems of the entire Great Lakes ecosystem. Toronto is both a contributor to and a victim of this situation. On a wider scale, in a world facing ecological and resource constraints, Toronto has a duty to conserve resources, including energy, food lands and fisheries, and raw materials.

Our present form of economic development, as a City and as a nation, is not sustainable. What is called for is a comprehensive strategy for a sustainable community that will put Toronto in the forefront of sustainable development - a concept that has been endorsed by the First Ministers in approving the recent report of the National Task Force on Economy and Environment. The strategy must examine how Toronto can conserve resources and protect its local, regional and global ecosystem. It must include targets for resource and energy conservation, pollution control, recycling and waste management and must be backed up with the requisite new by-laws, which might include an environmental "Bill of Rights" for the City and a comprehensive environmental by-law as well as measures to strengthen existing legislation such as amending the Offical Plan to include a set of environmental, health and sustainability criteria or toughening the existing Metro Sewer By-law. The proposed by-law to eliminate the production and sale of chlorofluorocarbons (CFC's) in Toronto is a good example of the sort of measure required.

City government should continue to set an example with its own practices, for example in not using CFC's, in using non-toxic alternatives to pesticides and in paper recycling and energy and fuel conservation programs.

The City already has in place the Environmental Protection Office, which is well placed to initiate this strategy and to involve Metro government. Such an approach is likely to be looked upon most favourably by the provincial and federal governments, from whom support can be sought. However, the strategy must involve all sectors of the community and will require a fundamental shift in our individual and collective values. This will require a comprehensive and long-term education and information strategy. Many of the environmental issues that affect health, the quality of life and the quality of the environment in the City are in fact a responsibility of Metro government. These include water treatment, sewage treatment, solid waste disposal and incineration. A Metro-wide equivalent of the national and provincial Round Tables on Environment and Economy would be a good place to begin.

Recommendations:

19. City Council seek enabling legislation to permit the City to adopt an environmental by-law that includes:
    - an environmental bill of rights for the City;
    - amendments to the Official Plan to include environmental and health criteria;
    - legislation to promote a sustainable community.
20. City Council establish a sustainability strategy for the City, (i.e., to include targets for resource and energy conservation, pollution control, recycling and waste management and the incorporation of sustainability criteria in the Official Plan).
21. City Council establish policies and practices consistent with substainability and health, including energy and resource conservation, recycling and the avoidance of toxic or environmentally harmful products.
22. City Council request Metro Council to establish a Metro Round Table on Environment and Economy, with linkages to the provincial and national Round Tables. Membership on the Round Table should include business, community, government, health and environmental groups. The Round Table should have the mandate of developing a strategy for Metro Toronto becoming a sustainable community.
23. Through the Department of Public Health Environmental Protection Office, the City participate in the proposed Metro Round Table toward the development of a sustainable community strategy and environmental protection activities.

4.2.3 Create Social Environments Supportive of Health

To create social environments supportive of health, we propose four main areas of activity. The first is community empowerment. Strengthening and facilitating the empowerment of the community has been a central theme in this Report and there is much that City government can do to facilitate the empowerment of communities in Toronto. Second, the community requires that informal care and support systems be encouraged and that formal care and support systems be strengthened. Third, we have to reduce violence and the fear of violence in our community and ensure a safe city. Finally, facilitating the empowerment of women is of particular importance.

Community Empowerment

City government can facilitate empowerment by enabling citizens to increase control over their lives and the conditions that affect their health. Empowerment is, in short, an extension of civic democracy via community development. This effort should be particularly focused on communities that currently lack power or are relatively powerless.

Empowerment has two prerequisites; the availability of information and the power to make choices based on that information. It is therefore important that information be provided to communities, in a manner that is accessible and understandable. Information to communities can be provided via libraries, community information centres and community centres. The information should be easily understood, locally relevant and available through computer networks and links.

In addition to providing information, community groups must be helped to take action. This can be done through the provision of meeting spaces, typing, copying and mailing and support services for the initiation of projects through supporting needs assessment and community education. A number of City departments already operate in this manner, and the City's grant systems should be strengthened in this regard. This would be helped by the development by City Council of a specific community development policy.

Another important aspect of community empowerment is the development of citizenship skills and a high sense of self worth, particularly in children. The Boards of Education have an important role to play here, and a program of citizenship skills development should be considered as a joint project of City government and the Boards of Education.

In addition, specific projects and processes might be considered focusing on particular areas of need. One such project is KidsPlace, a project originating in Seattle, which tries to address the city from the perspective of children - to make the City a child-friendly place. This led to such changes as the establishment of a Kids Board consisting of children with adult advisers who ran the project. This Board examines such aspects as the transit system from the point of view of children. What is unique and important about the project is that it gives children a direct voice in City decisions that affect them and it is thus an example of citizenship training and empowerment.

Recommendation:

24. City Council develop a Community Development Policy and facilitate community empowerment through its grants, through purchase of service agreements with community groups, where appropriate, and by ensuring that all City departments use community development approaches. In particular, the City should ensure that information on neighbourhood issues, resources and concerns is accessible and understandable at the community level and that children and adults acquire citizenship skills.

Community Support

Most care and support in the community is provided informally, by women. The question is how best to support these individuals and networks, in a manner that does not disempower them or replace them with formal systems that make them dependent. One way to do this is through the establishment of volunteer coordinators throughout the City whose task would be to strengthen and facilitate volunteer networks. Another approach would be to ensure that education stresses the importance and the practice of social support.

Formal community care and support services are mostly provided by Metro government, and the City's role in this respect would be primarily as an advocate for such services, particularly with respect to their accessibility, their multicultural appropriateness and their need to be empowering.

The City provides certain community services of importance to health, particularly recreation, fitness and leisure programs provided by the Department of Parks and Recreation. There are a number of ways in which these programs can further enhance the health and well-being of the people of Toronto. Joint wellness programs between Parks and Recreation and the Department of Public Health are one way of approaching these issues. We need to ensure that all publicly owned facilities should have, as their first priority, the provision of publicly accessible noncompetitive exercise programs.

Recommendation:

25. City Council examine the desirability and feasibility of establishing or supporting volunteer coordinators in local communities, working in conjunction with voluntary groups, to develop and sustain a network of community volunteers.

A Safe City

The vision workshops and the community and staff surveys showed that one of the most valued attributes of a healthy city is that it be safe, peaceful and nonviolent. The issue of a safe city, however, is not simply a matter of crime and violence, nor even the fear of crime and violence, though those are the most obvious and immediate issues. We also have to address the roots of violence in our society, and intolerance of difference and diversity.

As a recent report to the Neighbourhoods Committee noted, there is much that can be done to reduce crime and violence in the City, and to reduce fear, particularly in women. Such things as fundi g of women's groups working on safety issues; hostels for battered women; better designed lighting in carparks; on the streets, and in parks are recommended. There is also an identified need for "safety audits" of plans, more police foot patrols and just generally more people on the streets. In the report "Women Plan Toronto" the problem was also traced to the need for men to "learn how to better control their aggression" and be "nicer".

These comments begin to address the more fundamental roots of violence in our society, related to the portrayal of violence, and the acceptability of violence as a means of resolving problems. This in turn has deeper roots in an orientation to aggression, competition and patriarchy, and an intolerance of differences.

We need a widespread, long-term and conscious effort to orient our children and ourselves to peaceful rather than aggressive attitudes, to tolerance, to mediation of disputes rather than adversarial approaches, and to recognizing that the portrayal of degradation and violence, particularly violence by men against women and children, is the real pornography. Once you degrad people, you invite violence against them.

This calls for a broad strategy to make Toronto a safe city and requires the involvement of the Boards of Education, the police, the judicial system, women's groups and other community groups, to name but a few. Since the roots of violence and aggression are deeply embedded in our society, it also is a strategy that cannot occur in isolation in the City but has to involve, ultimately, the whole country. But we can make a start building a safer, more peaceful and nonviolent City. The Department of Public Health could contribute to this process by reporting on violence, its health impact, and its antecedents.

Recommendations:

26. City Council develop a broad-based "Safe City" Task Force to examine ways to reduce the level of violence in the community and to foster a more peaceful community.

27. City Council support and facilitate community-based action to reduce violence and increase safety.

28. City Council include a policy on public safety in the Official Plan.

29. The Department of Public Health report on the extent of violence in Toronto, its health impact and its antecedents.

Women, Power and Health

While women live longer than men, they report more ill health. Many of the inequities in health prerequisites fall most heavily upon women. Women are disproportionately represented among the poor. They are much more likely to be the head of a single-parent family and receive lower wages. They are the major victims of spousal violence and sexual assault. They are less likely to be well educated, and more likely than men to have to face the conflicting ethics of work and family and to shoulder the burdens of both.

The education and emancipation of women and their participation in the workforce have been the factors most closely related to fertility control both historically in the industrialized world and today in the less developed countries. Furthermore, since women are the principal providers of care in the family, their education has been an important factor in improving family health.

But, women are still relatively disempowered in our society. If empowerment is as central to health as we believe it to be, we as a community must continue our efforts to eliminate gender discrimination, ensure equal opportunity and reduce the burden of inequity in health prerequisites that falls upon women. Not only will this improve their health but the health of our society as a whole.

Recommendation:

30. City Council evaluate the impact of its policies upon reducing the social, economic and health inequalities of women.

4.2.4 Advocate for a Community-Based Health Services System

While Toronto has an excellent health services system, it is unbalanced, with too heavy a reliance upon institutions. There is a need to speed the transition of the health services system to a more balanced system with a strong community health services sector that will provide a viable alternative to costly institutionalization. This should not be interpreted as being "anti hospital" but rather a commitment to hospitals if necessary, but not necessarily hospitals.

The more balanced system we envisage would consist of a community-based system involving public health, community health centres and other forms of community-based primary care, home care, community support services, daycare/day hospital programs and free standing centres such as birth centres, abortion clinics and hospices.

A community-managed system is as important as a community-based system. This is consistent with the emphasis throughout the report on facilitating the empowerment of the community. The community should play a much greater role than it does in managing its health services system. Such an approach, which would integrate institutional and community services into a comprehensive community-managed system would be a more rational approach, rather than the current fragmented approach to health care system management. A community managed health services system would require, over time, the development of community boards, democratically elected, to manage the entire health care resources of a given community. This should be our long-term aim, but it will obviously require a great deal of discussion and further elaboration.

A third important aspect of a community-based health care system is that it should be accessible, particularly linguistically and culturally. The Department of Public Health, which has played an important role in the development of the Multicultural Health Coalition, and has supported the development of the multicultural community health centre and the Anishnawbe Health Toronto's Native Health Centre, must continue to play a leadership role in ensuring that Toronto's health service system is truly multicultural and that it meets the needs of the Native peoples.

Finally, we have to be concerned as a community and as a city that the funds spent on the health care system are spent wisely and well. There is insufficient evidence of the efficacy and cost-effectiveness of much of our health care system practices. As a city, we must insist on "the biggest bang for the health buck" and this means advocating with the provincial and federal governments for studies on efficacy and cost effectiveness. The

Metro Toronto District Health Council's proposal to include evaluation of effectiveness and efficiency in its strategic planning is a step in the right direction. It also means advocating for improved funding for public health and health promotion; City Council should support the Ontario Public Health Association's proposal to shift 0.25 percent of the provincial health budget to this sector every year for ten years.

While the City does not have a direct role in managing the health services system, it has, through its representatives on hospital boards and the Metro Toronto District Health Council, an important voice. In addition, through its Health Care Fund, the City has already indicated its commitment to supporting a community-oriented health services system and has proposed that 25 percent of the Capital Fund be earmarked for facilities primarily devoted to disease prevention and health promotion. The City's commitment to a community-oriented health care system and to disease prevention and health promotion should be strengthened and stressed through the City's representatives on hospital boards and the District Health Council, who should be briefed on the policy and on the need to represent the policy as City representatives on those boards.

Beyond that, City Council should be stressing to the Metro Toronto District Health Council the importance of developing health goals for Metro to complement the provincial and City efforts and, in particular, the need to document health status and health inequalities in Metro Toronto. The District Health Council's recent proposal to develop a strategic plan for health promotion and health care in Toronto so as to achieve improved health is welcome news and deserves our support. This effort should be complemented by the development by Metro Council of a social development strategy that incorporates health goals.

While there is a forum for the voice of the institutional health sector (the Hospital Council of Metropolitan Toronto) there is at present no equivalent voice or forum for the community sector. The Board of Health should develop a forum from which could emerge a coalition for a community-based health services system. Such a forum would enable the Board to reflect on its relationship with hospitals and the medical profession, to stress multicultural approaches and to bring together the various components and players that would comprise a community-based health services system for Toronto. This would be an important step in developing the City's policy with respect to a community-based health services system.

Recommendations:

31. City Council adopt a policy in favour of a more community-based and community-managed health services system and ensure that the criteria for awarding grants from the Toronto Health Care Fund are consistent with this policy.

32. City Council use its influence through membership on the Metro Toronto District Health Council and hospital boards to advocate for a more community-based health services system.

33. City Council advocate, along with the Ontario Provincial Health Association, that the province shift 0.25 percent per year of the annual provincial health budget to public health and health promotion for ten years.

34. City Council advocate to the Ministry of Health for studies of the efficacy and cost-effectiveness of the current health care system.

35. City Council support the intent of the Metro Toronto District Health Council to develop a strategic plan for health promotion and health care that includes evaluation of the system's effectiveness and efficiency.

36. City Council request Metro Toronto District Health Council to adopt health goals for Metro Toronto consistent with the provincial health goals proposed by the Ontario Health Goals Panel.

37. City Council request Metro Toronto District Health Council to prepare a report on health inequalities in Metro Toronto and develop a strategy to attain health for all in Metro Toronto.

38. City Council request Metro Toronto District Health Council to commit itself to developing a community-based and community-managed health services sector at least as good as the institutional health services sector.

39. The Board of Health establish a forum that would be the basis for a coalition working to develop a community-based health services system in the City of Toronto.

4.3 A Healthy City Strategy for the Department

Much of what follows in this section represents not so much a dramatic redirection of the Department programs and activities as a refinement and evolution of those programs. This reflects the success of *Public Health in the 1980's* in redirecting the Department a decade ago; thus many of the "new" directions listed here are already under development or are the topic of discussion in the Department.

The Department of Public Health will support the Healthy City Initiative through its programs and activities, thus helping to make Toronto the healthiest city possible. The Department programs must reflect three priority concerns: (1) to reduce inequalities in health and thus close the health gap by focusing on those groups whose health is most at risk; (2) to meet the diverse needs of Toronto's many cultural groups; and (3) to provide programs in a manner that facilitates the empowerment of both individuals and communities.

The Department's programs should be grouped into four areas, each of which relate to a specific goal. These four program areas reflect the current Department program priorities, while the goals reflect the proposed Ontario health goals. A fifth goal has been added to reflect the importance to the Department of supporting the City-wide Healthy City Initiative.

4.3.1 Increase Health Expectancy in Toronto

In this section, we are concerned with increasing the health expectancy of the people of Toronto by addressing the major causes of death, disease and disability in the community. (Health expectancy is expectancy of life in good health, or life expectancy less disability expectancy.) We have chosen to address these issues by focusing on two age groups - early in the life cycle and late in the life cycle - two settings - school and work - and seven sets of health problems - mental health, heart health, cancer prevention, prevention of substance abuse (tobacco, alcohol and drugs), healthy eating, dental health and healthy sexuality. Any of these health problems may be addressed at either of the main settings and the main lifecycle stages.

Healthy Parents/Healthy Children

Programs in this area address the needs of parents and preschool children. The needs of school-age children are addressed in the section on health at school.

The Department is involved in a wide range of programs affecting the health of parents and children, from family planning through planning for pregnancy classes, healthiest babies possible, prenatal classes, general prenatal visiting, hospital liaison, high-risk prenatal program, parents helping parents, parental bereavement program, parental support program and day nursery and child health assessment programs. Some of those programs are specifically targetted to high-risk groups, or intended for specific cultural communities, and a few of them involve community development approaches. What is needed is to develop a program that provides integrated parent and child health programs that are culturally sensitive and specific, and that use community empowerment strategies to address those with the greatest inequalities in health. An example of such a program is Parents Helping Parents, an innovative program that uses community development approaches to support parents from many different cultural backgrounds in disadvantaged communities to develop parenting and coping skills and to mutually support each other.

This emphasizes an important point in this program area - the importance of addressing the needs of parents and children together, as a family unit. As families become more stressed by the conflicting ethics and demands of family and work, by family separation and breakdown, by family violence and by the stresses of inner city living, their needs for new skills, for mutual aid and support and for empowerment become greater. On the other hand, the family is potentially a tremendous resource for health, since it is often the main factor in establishing health values, beliefs and behaviours in young children.

Although the proportion and numbers of young children in the population is declining, the large number of families with two parents working or with only a single parent has resulted in a growing demand for daycare, a demand that cannot be met through formal daycare programs. Thus, in addition to the growing need for the Department to be involved in regulated daycare programs to ensure safety, hygiene and good nutrition, there is an even greater need for the Department to work with those who provide unregulated daycare.

The Department's emphasis in this program area must be to help to ensure that children are born healthy and that they grow and develop in healthy family and community environments.

The first step must be for the Department to develop a comprehensive policy in this area and provide a well-integrated set of culturally appropriate programs that will help to improve the health of those parents and children who face the greatest inequalities in health.

Recommendations:

40. The Department of Public Health develop a Healthy Parent/Healthy Child Policy that emphasizes community development, family-based and culturally appropriate approaches. The Policy should:

    - advocate that parents and prospective parents have the information physical and social resources necessary for healthy growth and development of both parent and child;

    - strengthen formal community services and support informal networks for mutual care and self-help;

    - strengthen the family's capacity to establish appropriate health promoting values, beliefs and behaviours;

    This will be accomplished through:

    - provision of direct services (including health promotion and education, health protection, disease prevention. screening, counselling and related services);

- working with others in the community to ensure the provision of and advocate for services and resources for health (including daycare, housing, income support, and other social support and mutual aid programs);
- monitoring the health of parents, families and young children and identifying areas of need or concern.

41. The Department of Public Health programs for healthy parents and healthy children contain a significant mental health component, both to establish good parenting practices and to identify and help families at high risk of child neglect and/or abuse.

Healthy Seniors

Toronto can be greatly enriched by the full and active participation of seniors in civic life; their wisdom and experience provide a vast resource waiting to be tapped and they can make a significant contribution to the life and health of the City. We can learn much from the respect in which seniors are held in the many Eastern cultures present in Toronto. This can only happen if they remain active, healthy and involved residents of our community. The Department's policy statement on Healthy Seniors, adopted in 1986, declared that the mission of the Department of Public Health with respect to seniors is "To maximize the health status, functionability and autonomy of seniors" and that this could be achieved by:

- ensuring that seniors have the physical and social resources required to lead active, independent and meaningful lives;
- ensuring that both informal and formal community care and support services and networks, including mutual support and self-help, are available for seniors who need them;
- maximizing well-being among seniors, and reducing premature, preventable morbidity.

The policy identifies four major roles for the Department, namely:

- provision of direct services (health promotion, disease prevention, screening, assessment and referral, coordination, health protection, dissemination of information and access to knowledge);
- working with others in the community to ensure the provision of services and resources (including housing, comprehensive community care and home support services, multicultural services, monitoring of high-risk seniors, appropriate medical and dental care and appropriate community mental health services);
- advocating for better resources and services (such as improved pensions, good transportation services, improved quality of life for seniors in residences and facilities, and other appropriate municipal, provincial and federal policies);
- collecting and analyzing data and conducting research (with respect to the state of health of the seniors in Toronto, the determinants of health and disease, the effectiveness of the programs and implementation strategies).

Once again, it is important for programs to be culturally sensitive, address those in greatest need, and work through community empowerment. For example, the development of a comprehensive community health care and support system is particularly important for seniors, and the Department must be a strong advocate for such a system. Innovative approaches to providing a continuum of supportive housing are also necessary, including such initiatives, as a co-op nursing home.

The development of an extensive mutual support, mutual aid and self-help network could be greatly assisted if the Department had community development volunteer coordinators who are able to work with existing community organizations to mobilize a cadre of volunteers, both seniors and non-seniors.

Recommendations:

42. The Department of Public Health greatly expand its activities in the implementation of its existing policy with respect to seniors.

43. The Department of Public Health consider the desirability and feasibility of establishing volunteer coordinators in each Health Area, working in conjunction with voluntary groups, with a particular responsibility to develop support and volunteer networks for seniors.

Health at School

The policy statement, adopted in 1986, on the Department's role in the schools outlined five goals for the school program. These goals are stated below, followed by strategies to attain them.

1. Students should have the knowledge, attitudes and skills that will ensure a lifetime of healthful living.

   A healthy public policy for children at school would include:

   - the development by Boards of Education and the Department of Public Health of a comprehensive health education curriculum to be taught in all grades;
   - a curriculum that stresses such health promotive traits as mutual support, noncompetitive fitness programs, tolerance and respect for cultural diversity, and rejection of violence;

2. Young people should have access to health services that will prevent, detect early and act upon health problems so that they can receive optimal benefit from their education and realize their full potential.

   School health services require more emphasis on health promotion and disease prevention. Specific changes include:

   - participation with Boards of Education staff in developing and implementing a comprehensive school health education curriculum;
   - providing school health services more intensively to those in the community with the greatest health inequalities;
   - providing prevention and screening services as mandated under the Health Protection and Promotion Act;

3. School children should live and study in a safe and healthy environment that stimulates learning.

   School environments supportive of health would include:

   - minimizing the use of potentially toxic chemicals in the school environment;
   - banning smoking in all schools in the City;

- ensuring that schools provide or sell only healthy foods;
- developing a social support system that recognizes and respects differing levels of ability and different personalities and cultures, and that supports its weakest members.

4. Youngsters should be aware of how their bodies function, how the health care system operates and the major determinants of health in this society, so that they can make informed decisions that will promote community and personal health.

   Our children need to develop a wide range of personal skills. This will be helped immeasurably by the implementation of a comprehensive school health education curriculum. Personal skills need to be developed in the following areas.

   - developing self esteem;
   - learning positive health behaviours;
   - learning how to avoid negative personal behaviours;
   - learning to think critically about health information and anti-health advertising.

5. The school should be regarded as part of a community.

   The community will be strengthened if schools actively participate in their community and if children learn to work with others in the community (particularly seniors).

   - The community will also be strengthened if children learn how to take control over and improve their health, and to act both in the community and as a community in doing so.

   It is important that the Boards of Education and Department of Public Health work together. Negotiations are underway to establish a memorandum of understanding on the programs and services to be offered by the Department of Public Health in schools.

Recommendations:

44. The Department of Public Health work with the Boards of Education to develop a comprehensive health education curriculum; to promote and expand physical fitness programs, with an emphasis on noncompetitive exercise programs; to ban smoking in all schools; to minimize the use of or eliminate toxic chemicals in the schools; and to advocate that only healthy food is provided/sold in schools.

45. The Department of Public Health provide school health services that are culturally sensitive and specific; and are provided more intensively to those in the community with the greatest health inequalities.

Health at Work

This is a complex area, where the emphasis is upon the work setting and the conditions of work. (We are not concerned here with whether or not work is available. That issue has been dealt with in the section on Income, Work and Health.) Work should be a source of health.

Health at work has several components:

- Protection from physical, mechanical and chemical hazards. This includes occupational health and safety, industrial hygiene and right-to-know legislation. This has not generally been an area of responsibility for the Department of Public Health, except in responding to complaints in collaboration with the Ministry of Labour. However, the Department has been more involved recently through the passage and application of the Smoking in the Workplace By-law and the provincial "right to know" legislation. There remain some major occupational health and safety issues, particularly affecting small firms, that should be of concern to the Department. These include information on toxic chemicals and the availability of occupational health services. Further measures to improve indoor air quality in the workplace also should be considered.

- There is growing evidence that health at work requires that workers be able to increase control over and improve their working conditions and thus their health. Lack of control at work appears to be related to higher incidence of heart disease and other major health problems, including stress and mental health problems. The City of Toronto could set an example of healthy work by ensuring that its work settings and work practices are health enhancing.

- The workplace can provide an important setting for offering health promotion programs intended to promote health through strengthening community action, developing personal skills for health and providing physical fitness. Such programs provide a logical extension of employee assistance programs, and could be developed in collaboration with the Department.

Recommendations:

46. The Department of Public Health review its role in ensuring that small firms receive effective occupational health and safety services, and that their workers are informed on the use and hazards of toxic chemicals in their workplace.

47. The Department of Public Health develop workplace health promotion programs in collaboration with other health agencies, unions and employers, with particular emphasis on health promotion issues arising out of inequities in access to resources for health in the workplace.

48. The Department of Public Health investigate and report on a strategy to promote physical fitness programs in City of Toronto workplaces.

49. City Council ensure that those who work for City government have healthful work; this could be initiated by requesting the City's Occupational Health & Safety Committee to develop a "healthiest workplace possible" strategy.

50. The Occupational Health, Safety & Rehabilitation Division, Management Services Department, be requested to work with the Department of Public Health to develop a City policy on health at work.

Promoting Mental Health

> "Mental health means more than the absence of psychiatric symptoms. Mental health is about living life to the fullest, coping with life's demands and helping one another."
>
> Hon. Jake Epp
> Minister of Health & Welfare
> September 12, 1988

Good mental health has been a consistent theme running through the work of the Subcommittee. In part, this is due to an understanding which equates health with quality of life a very personal and subjective experience; in part, it is due to our relative success in addressing physical health concerns and our relative failure as a society in addressing mental health concerns; in part, it is due to the emergence of mental health as an issue related to poverty, bad living and working conditions, and widely reported problems of "stress"; and, in part, it is due to the recognition that mental health problems, in addition to the human costs, are a major factor in health costs. As a recent report from Health & Welfare Canada notes:

> "We cannot isolate our ideas about mental health from such wider social values as the desire for equality among people, the free pursuit of legitimate individual and collective goals and the equitable distribution and exercise of power."

A mental health strategy, as noted in the mental health policy review undertaken recently by the Department, must address itself to the fundamental determinants of good mental health. This may be done by ensuring that Toronto has a social and physical environment that fosters good mental health; determining ways to promote mental health and prevent mental illness and ensuring that there is a comprehensive community-based care and support system for those with mental health problems. In this area in particular, it is vital that the system be culturally appropriate and relevant to Toronto's multicultural community, and services be readily accessible, especially linguistically. Existing support services, which are often staffed by volunteers, and available in the gay and lesbian community, should be supported and developed for other groups.

Good mental health begins at birth, perhaps before birth, in the shaping of parental attitudes. Thus the Department's programs for healthy parents and healthy children should contain a significant mental health component, both to establish good parenting practices and to identify and help families at high risk of child neglect and/or abuse.

While we need to know a great deal more about how to promote the mental health of children, there is much that can be done in our schools and our community. If, as the evidence suggests, having friends is an important part of good mental health, then schools, the Department of Parks and Recreation and many other government and community agencies can play a vital role. Ensuring that children have a high but realistic sense of self-esteem is one of the most valuable contributions our schools can make to good mental health.

There is much that can be done to improve mental and social well-being at work. It is no longer enough to concern ourselves purely with occupational hazards and occupational safety, particularly when such a high proportion of our work force is now working in offices and the service sector, where physical, mechanical and chemical hazards may be less of a concern than in the old industrial plants. A system that humiliates workers and contributes to low self-esteem and self-worth may be one of the most toxic things in the workplace. There is evidence that high demand and low control in the workplace is bad for physical and mental well-being. We need to find ways of improving the quality of life at work, and of using the workplace to enhance mental health.

Mental health is equally a concern among seniors. Isolation, loneliness, loss of control of their lives and the pain of bereavement are faced as often by seniors as physical problems. The stresses of life for seniors, as for all age groups, cannot simply be swept under the rug of tranquilizers or antidepressants. Good mental health is an important component of a strategy for healthy seniors.

While there is much that we can do to enhance mental health and well-being, it is equally important that we ensure that those with mental health problems receive the care and support they require in the community. While deinstitutionalization is desirable, it cannot

and must not be at the expense of the deinstitutionalized. An appropriate range of supportive housing must be available for the psychiatrically disabled, together with an adequate income, work opportunities, social programs, training programs, and other community supports if deinstitutionalization is to work and self-reliance is to be encouraged. The Department must continue to be a strong advocate for and supporter of such a system.

Recommendation:

51. The Department of Public Health give much greater priority to mental health promotion and mental illness prevention. This should include:

    - parenting programs that are empowering and culturally appropriate;
    - programs to identify and work with high-risk families, such as the Parents Helping Parents program;
    - programs developed in collaboration with the Boards of Education and other appropriate community and parent groups that emphasize self-esteem, peer support, social networking and coping skills and resources for children;
    - mental health promotion programs in the workplace;
    - development of social networks and social support systems for seniors and others at risk of isolation, loneliness and vulnerability in thecommunity;
    - strong advocacy for an effective and comprehensive community mental health system;
    - monitoring and reporting on the status of the deinstitutionalized population;
    - research on mental health promotion and development of new mental health promotion programs.

Heart Health

Further reductions in deaths from heart disease will result from a comprehensive health promotion strategy incorporating all five strategies from the Ottawa Charter. The Department must take the lead, in collaboration with other City and Metro health agencies, in developing a comprehensive heart health strategy that addresses the multiple risks of the total population and seeks to reduce overall risk levels while targeting high-risk groups.

Healthy public policy for heart health requires:

- a City food policy that stresses high fibre, low fat, low salt, and low sugar diets;
- the encouragement of private and public restaurant and cafeteria facilities to provide heart healthy diets;
- continued public policy initiatives to reduce and eliminate tobacco use;
- work life policies that reduce strain and increase control.

Environments supportive of good heart health include:

- the availability of accessible, noncompetitive exercise facilities in all publicly-owned recreational facilities;
- an urban design that encourages walking, bicycling and other forms of exercise;
- elimination of exposure to secondhand smoke everywhere;
- the availability of affordable heart healthy food.

Strengthening community action around heart health issues involves:

- assisting in the development of community groups that will advocate for heart healthy policies and environments;
- ensuring that heart health programs are linguistically and culturally appropriate so that they involve the whole community.

Developing personal skills to ensure good heart health includes:

- ensuring that the entire population, from an early age, knows about, understands and adopts heart healthy lifestyle habits;
- developing programs that support people in adopting heart healthy habits and changing/dropping unhealthy habits.

Reorienting health services for heart health includes:

- providing good first aid services for those with heart health problems;
- comprehensive hypertension screening and treatment programs
- ensuring that those with heart health problems receive appropriate and effective lifestyle change programs and support;
- reexamining the efficacy and effectiveness of current therapeutic techniques and regimens.

Recommendations:

52. The Department of Public Health collaborate with other health agencies, community organizations and all other relevant groups to develop a comprehensive heart health strategy with the goal of "shifting the curve" i.e., a strategy aimed at the population as a whole. This strategy should include:
    - programs to develop and reward the development of heart healthy food products and restaurant menus;
    - tobacco reduction/elimination strategy;
    - culturally appropriate dietary goals;
    - culturally appropriate fitness and exercise programs;
    - heart health education programs;
    - effective hypertension screening and treatment programs.
53. The Department of Parks and Recreation and the Department of Public Health collaborate in the development of wellness programs to be offered through the City's community recreation facilities.

Cancer Prevention

While we know less about the causes of cancer than of heart disease, we are far from being ignorant of the causes. We know or suspect many of the most important causal factors in many forms of cancer.

The leading causes of cancer today are tobacco smoke, which alone contributes to 25 to 40 percent of cancer deaths and diet, which contributes to 10 to 70 percent of cancer deaths.

We strongly suspect that high fat diets are related to cancer. The American and Canadian Cancer Societies advise the use of low fat, high fibre diets with plenty of fresh fruit and vegetables and alcohol in moderation.

Fortunately, two of the most important defences against cancer - namely smoking prevention and eating a low fat diet - are also defences against heart disease. This makes the importance of taking action even more compelling, and perhaps increases the likelihood of achieving changes in policies and personal behaviours.

Other important known or suspected cancer causing agents include alcohol, ultraviolet light (hence the concern that destruction of the ozone layer will lead to an increased incidence of skin cancer) and toxic chemicals in the workplace and the environment. Many of the new synthetic organic chemicals which are known or suspected carcinogens are fat soluble. As they enter the food chain, they will concentrate in fats which we eat which is another good reason for switching to a low fat diet.

Through the Environmental Protection Office, the Department must challenge those who produce, distribute and market known or suspected carcinogens. There should be no discharge of such chemicals in our community and our ecosystem. The City could help by ensuring that its purchasing power is used to encourage noncarcinogens and nontoxic alternatives.

Another important part of cancer prevention is *appropriate* screening and early detection through such methods as the pap smear for cancer of the cervix, mammography for breast cancer and occult blood for cancer of the colon. New developments in molecular biology are likely to provide us with additional and more specific means of early detection of cancer in the next few years. The value and appropriateness of screening for cancer, as for any other disease, is something that requires careful consideration, and should not be undertaken lightly.

Clearly, a cancer prevention strategy calls for a broadly based approach similar to that suggested for heart disease. The Department should prepare a report on the scientific basis for a cancer prevention strategy for Toronto, linking it to the Heart Health Strategy wherever appropriate. Such a strategy must, of course, address inequalities and multicultural aspects of cancer prevention, and should use policy, environmental, community development, educational and health service techniques to create change. It must also involve collaboration with a broad coalition of community organizations and agencies, in particular of course, the Canadian Cancer Society.

Recommendations:

54. The Department of Public Health prepare a report on the scientific basis for a comprehensive cancer prevention strategy in the City of Toronto.

55. The Department establish a comprehensive cancer prevention strategy (linked, wherever possible, to the Heart Health, Healthy Eating and Prevention of Substance Abuse programs). This strategy should include:

    - tobacco reduction/elimination;
    - cancer prevention diet;
    - minimizing the use of and exposure to toxic chemicals at work, at home, in schools and in the community;
    - appropriate cancer screening programs.

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Preventing Substance Abuse

While tobacco is the most frequent substance that is abused, it is not addressed here since it is incorporated in the heart health and cancer prevention strategies. Instead the focus is upon alcohol abuse and illegal drug use, and to a lesser extent on abuse of prescription drugs.

To reduce alcohol abuse a comprehensive, multi-faceted and community-based approach is required and has already been approved by the Board of Health. At the policy level, there is evidence that policies related to alcohol pricing, restriction of its availability, increasing the minimum legal drinking age and increasing the probability of detection and punishment for drinking and driving may have an effect on alcohol use. All these policies have differential effects within different subcultures which require greater understanding. Where appropriate, the Board of Health and the City should continue to advocate to the provincial government for fiscal, distribution, licensing and advertising policies which will affect the use of alcohol.

A reduction in death and disease related to alcohol consumption will not come from policy change alone. The change in social values and attitudes towards drinking (the growing popularity of low alcohol drinks and no-alcohol teen clubs) and towards drinking and driving (RIDE programs, designated driver schemes, alcohol free parties, etc.) is evidence of a growing community concern.

The Department should continue and expand its community-based programs and participate in strengthening community groups and developing coalitions in the area of prevention of alcohol abuse as it already has in the Eastern Health Area. Alcohol abuse programs must consider cultural differences in attitudes and values towards drinking. Educational programs should provide the facts about drinking and its effects, along with an understanding of peer and social influences on use and abuse and techniques for self monitoring and control of drinking. Further, education about alcohol should be a central part of the proposed comprehensive health education curriculum, and innovative approaches to alcohol education, such as the "Steer Clear" rock concerts, should be encouraged.

There is no reason to believe that an effective strategy to prevent or reduce the use of illegal drugs will differ greatly from the strategy to prevent alcohol abuse. There may be an advantage in addressing the two topics together in a comprehensive substance abuse prevention strategy. There are no quick fixes to the illegal drug problem. The problem is rooted in a set of social values, norms and beliefs that will change very slowly, and is interrelated with a complex set of socio-economic factors.

Furthermore, the policy options available to deal with tobacco and alcohol problems (fiscal and regulatory policies) are not available because the drugs are illegal; we are forced to rely on criminal sanctions in the short-term and upon a longer-term approach that addresses the underlying social and economic factors.

However, the potential exists to develop a strong community-based movement to reduce the use of illegal drugs. The Department should be active in such an approach, preferably as part of a comprehensive substance abuse prevention strategy. Needless to say, education about illegal drugs should form part of the health curriculum taught in our schools.

Finally, the abuse of prescription and over-the-counter medication highlights another aspect of our "drug culture" - the belief in the "magic bullet" that will solve our problems in one shot. In this respect, physicians are as susceptible to this myth as the rest of society, perhaps more so. Abuse of prescription drugs may result from individuals shopping around from one physician to another. The high proportion of women on tranquilizers is one indication of the tendency of too many physicians to over-prescribe. These issues need to be addressed in a comprehensive substance abuse prevention strategy.

Recommendation:

56. The Department of Public Health develop a comprehensive data-based substance abuse prevention strategy. This strategy should include:

- addressing the root causes of substance abuse such as addiction, isolation, loneliness and stress;
- community-based alcohol and drug abuse prevention programs;
- participation with educational, enforcement, health and social agencies in intersectoral coalitions to prevent substance abuse;
- programs addressed to health professionals as well as the community to reduce prescription and over-the-counter drug abuse;
- collaboration with the Boards of Education to develop comprehensive substance abuse prevention and education programs.

Healthy Eating

In an earlier section, we addressed the City's role in ensuring that people have an adequate diet. Here we are concerned with nutritional value, and the role of the Department in ensuring that food is healthy.

The Department's role includes:

- food inspection for hygiene and safety;
- public education on nutritional issues;
- developing nutritional policies with other public and private sectors;
- provision of nutritional counselling services.

Food inspection is dealt with in the section on Community Sanitation.

Education about healthy eating, as with all our programs, has to be adapted to the varying needs of Toronto's multicultural community, and should use, whenever possible, a community development approach. The feasibility of establishing food guidelines for different cultural groups, in consultation with the groups themselves should be considered. An important program must be the education of people on ways to combat the marketing and advertising of unhealthy foods.

Education for healthy eating cannot take place in a policy vacuum. People's food choices are constrained by availability in the market place. The Department, in consultation with relevant local, provincial and national organizations, should develop a set of nutritional goals for a heart healthy diet. These goals would in particular reflect the need to reduce the proportion of fat and refined sugar in the diet, to increase the amount of fibre and to avoid heavily processed and salted foods.

Food choices are also constrained by lack of information. For example, allergies to natural foods, food additives such as sulphites may prove fatal. People have a right to know what is in the food they purchase, both in stores and in restaurants, and such information should be made available.

The establishment of a set of appropriate dietary guidelines and nutritional goals should be accompanied by a major collaborative effort with food manufacturers, retailers and restaurants to provide "heart healthy food". Models of such programs exist in the Heartbeat Wales program in the United Kingdom, the North Karelia project in Finland and else-

where. The program could be accompanied by incentives and awards for restaurants that provide heart healthy diets. The proposed City Food Policy Council would provide a suitable forum for such an initiative.

One way of dramatizing the links between diet, health and productivity might be to undertake research to examine the benefits to industry of a healthy as opposed to an unhealthy diet.

Finally, the Department must continue to develop and provide innovative dietary counselling programs for those with special dietary needs and for those at the greatest risk of harm to health from poor diets. This includes such programs as Healthiest Babies Possible and other nutritional supplementation programs that may be developed.

In short, the Department must undertake a major expansion of its nutritional programs to support both the "food for health" and the "healthy eating" programs. Healthy eating is also central to the Department's heart health strategy, the cancer prevention strategy and the dental health programs.

Recommendation:

57. The Department of Public Health, in collaboration with the proposed Food Policy Council, establish a Healthy Eating Program that includes:

    - culturally appropriate dietary guidelines and nutritional goals;
    - "right to know" by-law or provincial legislation which requires restaurants, food manufacturers and stores to inform people of the content of foods;
    - working with food producers, manufacturers, distributors, retailers, unions, nutritionists and food advocacy groups to develop programs for healthy nutrition;
    - advocating that only healthy food be provided or sold in schools;
    - research on the costs to business, industry and society of an unhealthy diet;
    - specialized dietary counselling as required.

Dental Health

The Department dental programs were reorganized in 1987, to target schools and children with the highest risk of dental health problems and children who lacked dental insurance coverage. The program also began to address the dental needs of seniors.

While this is a significant improvement in dental programming, and while the province has shown some initiative in developing programs for children and seniors, society has not acknowledged that all citizens should have access to good quality dental care. Of particular concern are those people in "the middle" who are not poor enough to have their dental needs covered by general welfare assistance and not well enough off to be able to afford private dental care or have it as an employee benefit. Although City Council has recently approved a geriatric dental treatment program, there is still a need for a comprehensive provincial geriatric dental treatment program.

Further, while the Department provides programs in different languages and in ways that are culturally appropriate, it is necessary to raise the profile of dental health in the community.

Community development approaches should be used to target dental programs to the hard-to-reach. The dental program should be planned in conjunction with the program on healthy eating to reduce the prevalence and accessibility of junk foods and high sugar foods, particularly in schools.

The dental health program must adopt and incorporate new technologies where they are of proven efficacy and cost effectiveness, and where appropriate should participate in research to develop new approaches to dental public health. These may include the development of vaccines to prevent dental caries; techniques of minimal repair and preservation of natural dentition using lasers; and research on the causes and effective treatment of periodontal disease. Finally, the dental program must continue to play an important role in the education of students in public health dentistry.

Recommendations:

58. The Department of Public Health advocate for the province to meet the dental health needs of those who lack either public or private dental insurance coverage through a program similar to the "Children in Need of Treatment" program.

59. The Department of Public Health continue to advocate for the province to develop a comprehensive dental treatment program for seniors.

60. The Department of Public Health continue to develop culturally and linguistically appropriate dental health programs and use community development approaches to enhance public awareness of dental health.

61. The Department of Public Health be involved in the research and development of new dental health approaches and development and adoption of new, efficacious and cost-effective prevention and treatment technologies.

Healthy Sexuality

At a time when AIDS, abortion and other issues related to sexuality are at the forefront of public discussion, it is important that they be addressed in a comprehensive manner.

Healthy sexuality is much more than safer sex. It is an attitude that acknowledges sexuality as a normal part of human relationships; that accepts and encourages love, caring and showing of affection; that rejects unequal power relationships as a basis for sexual behaviour; and that addresses sex, sexual orientation and gender-based inequalities and discrimination.

Healthy sexual behaviour recognizes that we have a responsibility to demonstrate respect for each other. This requires that both partners assume an equal role in use of safer sex practices to prevent AIDS, other sexually transmitted diseases and unwanted pregnancies. Individuals should be able to make informed and mature choices. Responsible sexuality means that individuals will inform their partners when they are at risk of contracting AIDS or other sexually transmitted diseases.

If we as a community are to develop a healthy and mature sexuality, we must begin at an early age to integrate this into the health education curriculum in our schools. It is particularly important to reach young people before and during adolescence, when their fears and concerns are greatest and when they are developing their sexuality and sexual identity. Parents must be involved in developing healthy sexual attitudes and behaviours in children. Finally, it is crucial that programs not be confined to the school but reach broadly into the community wherever young people and adults gather.

Recommendations:

62. The Department of Public Health develop a comprehensive healthy sexuality program that integrates all aspects of human sexual behaviour and that reaches broadly into the community wherever young people and adults gather.

63. The Boards of Education make healthy sexuality an integral part of a comprehensive school health education curriculum.

4.3.2 Create Healthful Environments and Protect People from Health Hazards

Responsibility for creating healthful environments and protecting people from health hazards lies with the City and higher levels of government. This has been extensively addressed in the context of the City Healthy City Initiative. But there are many areas in which the Department either has direct responsibility or plays a key leadership role.

Community Sanitation and Environmental Protection

For many years the Department programs in community sanitation and environmental protection have been provided by our public health inspectors. More recently they have been complemented by the addition of the Environmental Protection Office. Three major areas of concern now, and in the future, are food safety and hygiene; environmental inspection and control; and environmental protection.

A number of new approaches to improving food safety and hygiene are under development in the Department, and these should be encouraged and supported. They include food handler education, critical point monitoring (i.e., paying more attention to food handling at those critical points where contamination is most likely to occur) and outcome assessment of inspection programs.

In the future, consideration should be given to developing a program of restaurant certification for food handlers; a coordinated inspection and nutrition program to ensure that food is not only safe and hygienic but also nutritious; and an awards program for restaurants that provide nutritious or heart healthy foods.

There is an increasing concern with chemical contamination of food, as a result of the widespread use of pesticides and evidence of the presence of toxic chemicals. The feasibility of the Department taking a direct role in monitoring contamination of the food chain should be explored. It is vital that the Department continue to strongly press both the federal and provincial governments to expand their monitoring of food chain contamination, to work to reduce this and ensure that the public is fully informed of the extent of the problem.

Environmental inspection and control programs intended to improve the quality of the City's air, water and soil require the close cooperation between services and the Environmental Protection Office as well as with relevant agencies of Metro, provincial and federal governments. One of our most important public roles has been the improved monitoring of contamination of the beaches; unfortunately, the reduction of contamination is primarily a responsiblity of other levels of government.

The fact that North Americans spend 75 percent to 90 percent of their time indoors (roughly one-third of it in the workplace), and the development of energy efficient buildings with poor ventilation, resulting in the aptly-named "sealed building syndrome", creates a new concern for the Department. The City's Smoking in the Workplace By-law has made a significant contribution to improving indoor air quality for many people. The Department should now examine what else it can do to improve indoor air quality in Toronto.

There is concern with an apparent growing incidence of "environmental hypersensitivity" - some people seem to be abnormally sensitive to a wide array of synthetic chemicals, including pesticides, plastics, resins, perfumes and cigarette smoke. A 1985 report to the Ministry of Health concluded that a problem probably does exist and urged research and action on behalf of the victims. To date, little or nothing has been done.

The Board of Education has been concerned with the link between environmental hypersensitivity and poor school performance. It has embarked on a program to clean classrooms, provide windows that open, and reduce or eliminate the use of certain cleaning agents or pesticides.

The Environmental Protection Office was established in 1987. The important task of this Office in the next couple of years will be to consolidate its activities. The development of an ecosystem management approach to protecting the City's air, water, soil and food chain and the development of a strategy for a sustainable community are important holistic approaches to addressing the City's environmental problems.

The Environmental Protection Office should be involved in the developing health impact assessment techniques for use in land use planning and assessing other policies that may impact on health and environmental quality.

Right-to-know legislation provides an excellent opportunity to better understand the hazardous chemicals to which people are exposed at work and in the community, but also an opportunity to increase public awareness and to involve the community in decisions that affect their health. This should be strengthened by legislation that will require people to be informed when pesticides are used in their homes, offices, schools or neighbourhoods.

Recommendations:

64. The Department of Public Health consider the establishment of a restaurant food handler certification program and a nutrition awards program.

65. The Department of Public Health consider its role in the monitoring of chemical contamination of the food chain, and advocate to the provincial and federal governments for them to expand their monitoring to undertake programs to reduce food chain contamination and to inform the public of its extent.

66. The Department explore what role it can play in improving indoor air quality in the City of Toronto.

67. The Department of Public Health review the evidence that suggests environmental hypersensitivity is an important new public health problem and propose appropriate actions.

68. The Department of Public Health Environmental Protection Office actively participate in research for new techniques of health impact assessment.

69. The Department of Public Health consider a pesticide right-to-know by-law to complement provincial right-to-know legislation and undertake a comprehensive information and education campaign to ensure that the public are aware of toxic chemicals to which they are or may be exposed.

70. The Department of Public Health Environmental Protection Office assume a leadership role with respect to environmental protection.

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Communicable Disease Control

Historically, communicable disease control has been one of the most important functions of public health. As the AIDS epidemic reminds us, it remains an important public health function, but changing times have brought changing needs. In particular, the growing number of daycare facilities have called for infection control programs, a need to which the Department has responded. The growing proportion of seniors, and thus the growing numbers of nursing homes and homes for the aged present special problems of infection control. Again, the Department has begun to respond to these needs, and this will prove to be an important new area of infection control.

In response to AIDS a number of innovations in communicable disease control have been examined and implemented. The adoption of human rights legislation in the seventies and eighties has led to questions regarding the role and necessity of traditional public health practices and legislation. Mandatory screening and sero-surveys are not viable solutions to the control of AIDS. Unlike previous epidemics the main line of control has been through education.

The social and political nature of the disease has been well voiced by many minority groups and individuals affected. Many persons with AIDS have rejected victimizing and stigmatizing labels. Increasingly, there is an awareness of the need to develop culturally, socially sensitive and particularly nondiscriminatory educational messages. Further, important educational messages should address techniques of disease prevention and mental health issues of healthy sexuality, coping and enhancement of mutual respect between individuals.

In response to AIDS, there has been a tremendous development of volunteers in the community. Many of the innovations in education, prevention and service delivery have been community-based. This has allowed public health agencies to view their role as one of greater shared responsibility and as an empowering one. These lessons learned from AIDS should be applied in other areas of communicable disease control and public health practice.

Recommendations:

71. The Department Public Health play a significant role in infection control programs in both regulated and unregulated daycare facilities.

72. The Department of Public Health ensure the development of infection control programs in all collective living centres in the City of Toronto.

73. The Department of Public Health apply the lessons learned in endeavouring to control AIDS to the development and enhancement of other communicable disease control programs.

4.3.3 Enable the People of Toronto to Develop Health Promotion Skills and Achieve Their Health Potential

If the people of Toronto are to achieve their full health potential, they will not only need public policies and environments which are supportive of health and communities which are strong and empowered, they will also need a range of health promotion skills. These are not limited to personal health behaviours alone, but include skills related to personal empowerment, group and social interaction, public participation and involvement in the community and in the political process.

The Department can support people in acquiring these skills in three important ways: through health education techniques which should be a part of all the Department's programs and are one component of multi-faceted multiple risk reduction strategies; through ensuring that the Department's staff and programs facilitate the empowerment of individuals and communities and through providing linguistically, culturally sensitive and appropriate information about health to the people of Toronto.

Health Education

Health education, in the traditional sense of individuals' acquiring specific knowledge and attitudes leading to behaviour change is only one component of a comprehensive social change process that will lead to improved health. While it is important that the Department have resources and expertise in health education in specific areas, it is even more important that the Department have staff who can provide advice on multi-faceted, multi-risk factor programs. This will be particularly important as the Department develops programs for heart health, cancer prevention, mental health, prevention of substance abuse and other areas highlighted in this report. Techniques of popular education are an important new approach, particularly in trying to reach children, new immigrants whose English is poor or those with problems in reading.

It is important that professional staff development occur throughout the Department to ensure that all staff have the requisite health education skills.

Community Development in A Multicultural Society

Community development and culturally appropriate programming have been highlighted throughout this report. The Department must have consulting strength in both of these areas, and it must involve all Health Area staff and strengthen staff training and development in community development and multicultural health aspects.

Recommendation:

74. The Department of Public Health ensure that it has sufficient expertise in the areas of health education, community development and multicultural health, and undertake extensive and ongoing staff development in these areas.

Health Communications

The challenge for health communications is not only the development of advertising and publication projects for the Department, in support of it major programs, but the development of materials in consultation with the multicultural communities in Toronto. This may require expanded budgets and staff resources for health communications, and close links with such organizations as the Multicultural Health Coalition.

One important way to reach people with a health message is via the media. The Department should continue to work closely with all Toronto's media in spreading health communications; again, the use of Toronto's many cultural media outlets should be a special focus of activity.

In view of the high level of functional illiteracy in the population, it is essential that the Department have consultant expertise in communications strategies that will ensure that the Department health education programs and communications reach those who have low literacy levels. The Department should work closely with community organizations and programs that work with such people to ensure that health is a part of their educational work.

The Department should explore ways in which its Resource Centre Collection can be made more available to the community, either through Health Area-based centres, through computer information systems or through close cooperation with City of Toronto Libraries and Community Information Centres. It will be important to identify what unique role the Department Resource Centre can have in enabling people in Toronto to develop health promotion skills and achieve their health potential.

Recommendations:

75. The Department of Public Health continue to prepare culturally appropriate health communications, including communications suitable for those who are functionally illiterate.

76. The Department of Public Health examine ways in which the Department Resource Centre can make health information more readily accessible to the community.

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4.3.4 Plan for Health and Provide Health Data

Three distinct functions can be identified in the area of health planning and use of data. The first is health planning itself, the second is the collection and distribution of data about the health of Toronto, and the third is health research.

Health Planning

The Department must continue to undertake effective health planning, both strategic and program planning. As a first step, this will require the Department to develop specific goals, objectives and measurable outcome targets in the four program areas and the 22 health programs identified in this report. A five-year plan should be developed, with regular reports to the Board of Health every two years and renewal of the plan every five years. Obviously, health planning includes the regular evaluation of the Department's programs and activities, monitoring progress and identifying problems so corrective action can be taken. Given the overall Departmental function of health planning, the Department should report on the desirability of placing the health planning function within the Office of the Medical Officer of Health.

Recommendations:

77. The Department of Public Health prepare a five-year plan, with objectives and targets for each program in this Report; biennial progress reports should be made to the Board of Health.

78. The Department of Public Health consider locating its planning function in the Office of the Medical Officer of Health.

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Health Data

The Department must continually collect data which supports both the Department's Healthy City Strategy and the City's Healthy City Initiative. Thus, in addition to specific program data for heart health, cancer prevention, environmental protection and other programs (such data to include information on major health determinants, perceived health, health behaviours, morbidity, mortality and program activities) the Department must develop outcome measures for its programs. It is particularly important that the Community Health Survey be repeated on a regular basis.

Beyond the Department's specific program-based data needs is the need for information to support the City-wide Healthy City Initiative. Here the Department's data section must develop and analyze information relevant to reducing inequalities in health, link data on food, shelter, work, education, income, environmental quality and other aspects to health. These profiles can become an important catalyst for community action around health.

Data can play an important role in community development. In consultation with neighbourhood groups, the Department should regularly produce ward or neighbourhood profiles of the major health problems, neighbourhood health resources, and other relevant information.

The data section also must support the Department's multicultural activities by providing data relevant to Toronto's cultural and ethnic communities. The Department should examine the extent to which it can provide health information data directly to the community.

The Department should develop "healthy city" data in consultation with the European and Canadian Healthy Cities projects, and a five-year health information strategy should be developed that relates to WHO Europe's five-year plan for the Healthy City project.

Recommendations:

79. The Department of Public Health develop new data relevant to the City-wide Healthy City Initiative, including new Healthy City indicators; this information should be developed in collaboration with the proposed Healthy City Office and with the Canadian and World Health Organization projects.

80. The Department of Public Health prepare a detailed report on health inequalities in the City of Toronto.

81. The Department of Public Health prepare neighbourhood health profiles that are easily understood and readily accessible; these should highlight issues relevant to inequalities in health status and to multicultural aspects of health.

82. The Department of Public Health report on the feasibility of providing a health data information service to the community.

83. The Department of Public Health develop new program data, including outcome measures, that will enable the Department to evaluate its progress with respect to the five-year plan.

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Health Research

Our new understandings of public health, health promotion, healthy public policy and healthy cities will require a great deal of research to: identify and evaluate new indicators; assess impact; examine social and environmental determinants of health; and evaluate effectiveness of multiple-risk-factor reduction strategies in heart health, cancer prevention, and promotion of mental health programs. A Department Research Committee could help to identify research priorities, coordinate the Department's research resources and seek research funds.

As a consequence of the increasing attention being paid to health promotion internationally, nationally and provincially, there are proposals under development to establish new health promotion research and teaching programs at the University of Toronto, York University and Ryerson Polytechnical Institute. The Department should offer to collaborate with these institutions in developing health promotion initiatives. Such programs would likely attract high levels of funding support from federal and provincial health research agencies.

The Department should examine ways in which such a research program could be affiliated with the City's proposed Urban Institute, as well as other ways in which the Department could play a role in such an Institute.

Recommendations:

84. The Department of Public Health establish a Research Committee which should, as its first task, clarify the Department role in research and develop a health promotion/public health research strategy. The Research Committee should identify priority areas for research, with particular reference to the City-wide Healthy City Initiative, coordinate the Department research resources and seek research funds.

85. The Department of Public Health collaborate with the University of Toronto, York University, Ryerson Polytechnical Institute and others in developing health promotion initiatives.

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4.3.5 Support The Healthy City Initiative

As has already been noted, the Department cannot by itself make Toronto the healthiest city possible. To do so will take the combined efforts of City government and the community.

However, the Department has an important contribution to make, both as the crucible within which the healthy city concept has been forged and the source of health expertise and information. At the same time, through its programs and activities, the Department comes into direct contact with the community, other agencies and other City and Metro departments, and is in a key position both to influence and work with them.

Healthy City Strategy Section

In order for the Department to contribute effectively to the development of the City-wide Healthy City Initiative, a section should be established within the Department with a mandate to provide the liaison, coordination and policy development and analysis needed.

The Healthy City Strategy Section would be the main link to the proposed Healthy City Office. The Section would play a particularly important role in addressing issues of equity and providing data on inequalities in health within Toronto; in supporting the development of healthy public policies by providing health status data, health impact assessments and health policy analysis; and in contributing to the development of a community development strategy for the City.

The Section would be responsible for coordinating the Department's efforts with respect to the City-wide initiative, for chairing the Department's own Healthy Cities Workgroup, and for liaising with the Canadian Healthy Communities Project, the WHO Healthy Cities project and other relevant international links.

Recommendations:

86. The Department of Public Health consider establishing a Healthy City Strategy Section within the Office of the Medical Officer of Health to coordinate work with other departments and provide linkages to the proposed Healthy City Office, the proposed Inter-Departmental Healthy City Workgroup and the proposed City Healthy Public Policy Committee.

87. The proposed Healthy City Strategy Section provide health-related data and consultation relevent to all aspects of the City-wide Healthy City Initiative, and be responsible for developing analyses with respect to inequalities in health.

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Staff Development

The importance of staff training and development for the success of the Department's Healthy Cities Strategy cannot be over-emphasized. The Department must ensure that it has well trained staff who are aware of the latest developments in public health, especially in such priority areas as health inequalities, community development and the needs of culturally diverse populations. In addition, some professions are required to undertake a specified amount of continuing education in order to maintain their certification.

This calls for a comprehensive staff development strategy with a budget to meet staff training and development needs; the current budget is completely inadequate, hampered by a City Council policy that severely restricts professional training and development. While the cost of good training and development programs is not small, neither is the cost of an inadequately trained staff. A suitable budget target should be established, expressed as a percentage of the Department's budget, exclusive of salary costs for staff on training and development time.

The Department's existing staff development resources should be reviewed, to determine whether additional resources are necessary. The importance of working closely with the Department's health education, community development and multicultural consultants, as well as with more program specific consultants, should be taken into account in deciding on the most appropriate location for the Department's staff development program.

Recommendation:

88. The Department develop a long-term and comprehensive staff training and development strategy to ensure that all staff are aware of the Healthy City Initiative, such priority areas as health inequalities, community development and multicultural health issues and other matters. This staff training and development strategy should include a budget adequate to the task.

Education and Training of Community Health Professionals

If the Department is to continue to play a leadership role in these new and exciting areas of public health, it is essential that new generations of health professionals - both those working in public health and those working more generally in the community's health system - learn about and apply these new concepts. Thus the Department should complement its research activities by playing an even greater role in the education and training of community health professionals; current collaboration with the University of Toronto and Ryerson should be developed into formal Teaching Health Unit arrangements, and similar collaboration with other centres of higher education should be encouraged. These activities should also serve to strengthen our staff development and community development and education activities through reciprocal arrangements with the relevant faculties. Exchanges between staff and community-based volunteer organizations dealing with specific population groups should be encouraged.

Recommendation:

89. The Department of Public Health collaborate with the University of Toronto, Ryerson Polytechnical Institute, Community Colleges and other centres in the education of community health professionals through formal Teaching Health Unit programs.

Vision of the Healthy City

Postscript: Where It All Leads - A Vision Of A Healthy Toronto

At an early stage in our work, we set out to develop an image, a vision if you prefer, of our eventual purpose. What would a healthy Toronto be like, we asked ourselves, over 200 members of the Department's staff and 15 community groups. From their answers, we have compiled the following scenario, written as if it were a report on the state of Toronto in the year 2000. We offer it as a guide, and perhaps an inspiration, to the people of Toronto and the staff of the Department of Public Health as they work to make Toronto the healthiest city possible.

The State of the City Report, Toronto, February 2000 A.D.

Today the City of Toronto celebrates its 166th birthday and a new millennium. We will use this occasion to reflect on our progress of the past twelve years. In 1988 we adopted the healthy city strategy and started work on making Toronto a prime healthy city by the year 2000. Back then, we envisioned an ideally healthy Toronto.

What was our vision? Have we attained our goals? What challenges do we still face? Before we begin let us commend the foresight of the civic leaders of the 80's who realized that we must always strive, as individuals, as communities and as a City. Thanks to their initiative we are much healthier than we were, no small achievement!

But what about the vision created twelve years ago, beginning with the physical environment. People wanted a wholesome environment, free of pollution, quiet, green and healthy. They wanted fresh air indoors and out, clean water to swim in, pure water to drink; they wanted effective and safe waste disposal, safe work places, uncontaminated food and air free from tobacco smoke and car fumes. They imagined attractive beaches, edible trout in the rivers, greenery, waterfalls and fountains.

Of course, they did not imagine that this would all just happen. They anticipated a sensitive community committed to improving, protecting and preserving the environment, and responsible integration of the built and natural environments. We would care for our urban ecosystem, they hoped, through appropriate community technology: recycling garbage and waste; an ecologically sound sewage system; quiet, efficient and nonpolluting public and private transport; a local food production and distribution system using few chemical additives; a responsible integration of architecture and environment.

People wanted neighbourhoods built to human scale, fewer highrises, more lowrises and restoration of old buildings. They imagined parks, gardens, trees, grass, community gardens, vegetable plots, sunshine, outdoor recreational facilities and community shopping areas. The ideal neighbourhood would be readily accessible to the disabled, the young and the elderly.

The health visionaries of the 1980's anticipated appropriate and affordable housing for all, provided in a humane, comprehensive and integrated fashion, housing of high physical quality, including co-ops and supportive housing for seniors, the disabled and others with special needs. They saw housing beside shopping and recreational facilities, mixing old and new neighbourhoods for variety and interest.

The planners foresaw an integrated, efficient and effective transportation system, one that encouraged pedestrians, bicycles, and public transit and that reduced the use of cars in the inner City. However, they believed that people should be able to get around easily, and that good rapid transit (surface or air) between major centres was essential. The benefits would be reduced air pollution, home and work in closer proximity, less congestion. They saw a reliable, hasslefree, people-oriented transportation system producing a totally accessible City.

They believed that these benefits would come about when raised civic consciousness resulted in participatory democracy, and neighbourhoods would be empowered. There would be a heightened sense of community, of concern for others and a resurgence of volunteer and selfhelp groups. City Hall would be open and interactive.

A caring and sharing community would see itself as a family with support groups, volunteers, and community networks. It would accept differences, and celebrate diversity, close-knit multi-generational families and neighbourhoods. Those in trouble would be helped and cared for within the community. People would feel relaxed, happy, safe, secure and loving; interdependence and diversity within neighbourhoods would be the rule.

Basic needs would be met, and hunger and homelessness eliminated. Work would be available to all who wanted it; there would be equal opportunity in employment and education and the social stigma attached to welfare would be removed. People would be given a handup instead of a handout. Everyone would have enough money to live with dignity and self respect.

Toronto has always been a safe city, and safety remained a priority. They recognized that feeling secure is the result of a nonviolent community in a world where violence and the threat of nuclear war had been reduced or eliminated. Nonviolence meant not only safe, clean, and well-lit streets; but also an end to physical and sexual violence and the exploitation typified by prostitution and pornography. Essential to the creation of a peaceful community were nonviolent programming on television and at movie theatres, and a society where diversity is accepted, where people show respect and where the environment is safe and nurturing.

Security and well-being also stem from a healthy and humane work life. Work would be important, the planners believed, but more flexible, and varied, including part-time and shared work. more leisure, more recreational and service facilities at work, and better daycare. The ideal was meaningful work in a friendly, participatory and cooperative atmosphere. A shorter week and flexible hours would ensure work for all. Work would be a source of health, with people seen as ends rather than means.

All these changes would create a need and an opportunity for learning. People would realize their full potential by learning and living.

In the ideally healthy Toronto, people would be motivated to adopt healthy lifestyles. The physical and social environment would contribute to balance with less stress and enhanced mental well-being. Proximity to work, school and play would produce a less rushed and hectic life, with more time for physical activity, relaxation and community involvement. This healthy lifestyle would be enhanced by stringent controls on smoking in public places, policies promoting healthier foods in restaurants, exercise breaks at work and responsible sexual behaviour designed to reduce teenage pregnancies and sexually transmitted diseases.

The healthy city would focus on nutrition, not only to prevent hunger but also to ensure that wholesome food would be readily available in stores and restaurants. In the year 2000 there would be less junk food and fewer additives.

Recreational opportunities would highlight the healthy Toronto of the future with open space, beautiful sites with flowers, trees and plants, bicycle paths, jogging tracks, and skating rinks. Quiet and peaceful green areas would complement high quality recreation facilities readily accessible in each neighbourhood.

A healthy and fit life would be supported by a superior health care system. A wide range of high quality, available services, would emphasize health promotion, disease prevention and community rather than institutional care. This restructured illness system now a wellness system, would control most health problems.

Public Health would aim for quality of life, particularly for those with special needs. Improved services would facilitate self-sufficient lives. Seniors would enjoy a dignified retirement with opportunities and options. Daycare would be available so that all children would receive the best care.

In short, health for all.

Well, that is what they wanted, in 1988. Now let us look at what has actually happened in the intervening twelve years, and how we have progressed in our efforts to make Toronto a healthier city. Today we can say...

(Editor's Note: At this point, our timewarp link was damaged by a current surge which broke our chronocommutator, and we have been unable to reestablish contact. Readers will have to wait some time for the rest of the report, which will be available any time after February 2000 A.D., from City Hall, Toronto.)

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Appendix I

Terms of Reference

Healthy Toronto 2000 Subcommittee

1. That the Subcommittee begin with a review of the report *Public Health in the 1980's*. It should review each of the sections to see if they have been implemented, what further needs to be done and if recommendations were inappropriate - why. It should do so primarily in consultation with the staff concerned and the Community Advisory Boards. Further, the Subcommittee should review the reorganizational report for the Public Health Department and determine if further efforts are necessary to study the appropriateness of the present Departmental structure.

2. That the Subcommittee review and update the history of the Department and Board of Health as part of its work.

3. That the Subcommittee then seek expert advice from within and without the Department to determine what will be the major health challenges faced by the City of Toronto during the 1990's.

4. With the above material, the Subcommittee should begin a consultation process with the staff and community-at-large to determine the appropriateness of the Department and Board's policy and structure in the face of these challenges.

5. That as part of this latter process, the Subcommittee should consider a broader consultation program, and a revised structure for itself appropriate to posing the question: What needs to be done to make Toronto a healthy city? - in the broadest sense of this term. This question will, by its very nature, go far beyond the scope of the Public Health Department and relate in fact to all aspects of City and Metro Governments and to the community beyond. In so doing the Subcommittee should consider the emerging concepts of the "Healthy City Strategy".

   To break down this big job, we subsequently developed the following goals:

   a) To provide policy guidance to the Department for the next decade.

   b) To provide leadership to the City administration in the development of a coordinated plan for Healthy Toronto 2000.

   c) To prepare reasonable and data-based arguments for making health a priority on the political agendas of the City, provincial and federal governments.

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Appendix II

Summary of Responses To The Healthy Toronto 2000 Survey

1. Introduction

   The Healthy Toronto 2000 Subcommittee distributed a discussion paper to the community and the staff of the Department in Fall 1987. The paper included a questionnaire. We received 211 responses from the community and 59 responses from Department staff, and the results are presented here. These numbers substantially underestimate the actual response, since a number of responses both from the community and the Department are from groups rather than individ-

uals. In addition, over one hundred community members and over two hundred Department staff had earlier participated in vision workshops.

Before discussing the results, it is important to stress that this was not a representative sample. The responses simply indicate the values and priorities of those selected (and self-selected) individuals who responded to the questionnaire. Nonetheless, the results provide a consistent picture of the views of this group.

The first section of the report describes a healthy city from the perspective of the respondents. Their response to the question "What 4-6 words or phrases come to your mind to describe a healthy city?" are tabulated in terms of the major categories of the vision as described in the discussion paper, with additional categories where warranted. The number of responses for each category, and for each item within each category, gives an indication of the relative importance attached to each item and category.

The second part of this section of the report shows how the issues identified by the Subcommittee were rated by respondents, in terms of the challenge to health and the role of the Department of Public Health. Differences between the importance of the challenge to health and importance of the role of the Department are highlighted; differences between community and staff perceptions are also shown.

Finally, this section indicates what the respondents would add to or remove from our list.

The second section of the report describes the respondents' answers to the question "If you were on City Council, what are the first three things you would do to make Toronto a healthier city?" and "What three things could you or your organization do to make Toronto a healthier city?" These responses are grouped in terms of the most frequent recommendations and suggestions for action.

2. What Is a Healthy City

a) Describing the Healthy City

In response to the question "What 4-6 words or phrases come to mind to describe a Healthy City?", the largest single category of response from the community related to the physical environment. This category was almost three times as large as the next largest category. If the issues of housing, meeting of basic needs, provision of healthy food and healthy work were grouped together they would amount to a category two-thirds the size of the environment category. Within the environment category, the overwhelming sentiment was for a clean environment, including clean air, clean water and clean streets. Other items within the environment category included a pollution-free environment or one with minimal pollution and a quiet environment.

The next largest category was that of safety, peace and nonviolence. Safety was one of the most frequent single items mentioned. A number of other responses dealt with protection from violence and crime. Another important item within this category was peacefulness, less hatred, acceptance of diversity and tolerance of differences.

The third major category dealt with housing, revolving around issues of affordable, good quality and adequate housing for all. The fourth major category was that of green space and parks, with trees, grass, flowers, water, etc.

The notion of a caring community full of friendly people was the fifth major category, reflecting people's desire for a sense of community spirit, involvement, fellowship and support.

Issues of neighbourhood and urban design were the next category, with concerns focusing on human-scale, lowrise, less congested but diverse neighbourhoods. The meeting of basic needs for all, the elimination of poverty, the presence of a healthy economy and the provision of equity of opportunity was the next important category.

Other important categories included the provision of healthy food; good cheap accessible transit together with a strong emphasis on provision for walking and cycling; a community

free of disease with vigorous long-lived people in good physical and mental health; widely accessible community support services, particularly for the most vulnerable, including daycare, volunteer programs, etc.; high-quality accessible health care services including hospitals, health centres and home and community care; full employment with some attention paid to the quality of the work experience; a healthier, slower paced and less stressful lifestyle that encourages development of full human potential; health promotion and disease prevention programs emphasizing better education of children and parents; a good education system; accessible sport and recreation facilities and activities; good waste management stressing recycling; and at the bottom of the list, accessible and responsive city government that involves people in planning and decision making.

In addition, a category emerged that described the nature or quality of the City - that it be active, changing, free, vibrant, exciting, happy, progressive, aware, fun, busy, alive, dynamic, usable, enlightened, compassionate, just, self-sufficient, cooperative, meaningful, stable, organized, ambitious, responsible, forgiving, efficient - a good place for people and animals!

The responses from the Department's staff were not noticeably different. The major categories included environment, safety/peace, housing, neighbourhoods and parks, with the only major difference being the elevation of good health to third place. The most common words used to describe the healthy city, as for the community, were clean, safe, green, pollution-free, with shelter for all and affordable housing.

b) Assessing the Challenges to Health

Since the largest group of respondents was the community, and since they were asked to first rate the extent of the challenge, this rating will be used as the bench-mark for discussing both the rating of the challenge by the Department's staff and the rating of the Department's role by both the community and the Department's staff. In this section, all percentages reported are of those respondents who rated the challenge and the Department's role as being either great or very great (i.e., 4 or 5 on a scale of 1 to 5).

The most significant challenge to health was identified by the community as homelessness and lack of affordable housing, closely followed by environmental pollution. Poverty was a close third, while hunger and poor food quality ranked fourth. Next in order were the challenges posed by more seniors, unemployment, violence, the threat of nuclear war, illiteracy, changes in family structure and underemployment. The only challenges where fewer than half of the respondents rated them important or very important were the multicultural nature of the population, population growth and the presence of fewer youths in the city.

By and large there was close agreement between the community's assessment of the challenges and the Department's assessment of them. The only major differences (i.e., those where the difference was more than ten percent) were with respect to the multicultural composition of the community, violence, and the increasing population of seniors. In each of these instances the Department rated the challenge to health as greater than did the community.

In the terms of ranking the challenges, there was very little difference, except that the Department's respondents ranked poor food quality somewhat lower and the multicultural community, violence, and the growth of seniors somewhat higher.

c) Assessing the Role of the Department

There are a number of major differences between the community's assessment of the challenge and its assessment of the role of the Department; we are concerned with those where the difference in percentage rating is 20 percent or greater. The most notable differences were a 30 percent or greater difference in the areas of underemployment, unemploy-

ment and lack of affordable housing and a 20 percent or greater difference with respect to the Department's role in meeting the challenges of nuclear war, poverty, violence, homelessness and illiteracy. In all of these cases, the Department's role was ranked as much less important than the extent of the challenge.

None-the-less, more than half of the respondents rated the Department's role as important or very important in the following areas: Pollution (82 percent), poor food quality (75 percent), homelessness (71 percent), hunger (69 percent), a high proportion of seniors (64 percent), poverty (60 percent) and lack of affordable housing (58 percent).

The Department staff's assessment of the Department's role in meeting the challenges showed a similar pattern to that of the community's assessment. The Department staff ranked the Department's role in pollution highest (as did the community), its role with respect to seniors and the multicultural community more highly, and its role with respect to the housing crisis much lower - less than half the Department staff respondents thought the Department has an important or very important role to play in this area.

The difference between the Department staff's assessment of the challenge and the Department's role in dealing with it showed some dramatic differences, most notably with respect to the lack of affordable housing where it was 42 percent; the difference with respect to the role in response to underemployment was 33 percent while differences of 20 percent or greater included unemployment (26 percent), illiteracy (23 percent) and nuclear war (20 percent). In all of these cases, the Department's role was seen as less important than the challenge to health.

The most important differences between the Department staff's assessment of the Department's role and the community's assessment of that role was that the staff saw a much greater role for the Department in dealing with the challenges posed by more seniors (23 percent higher) and by the multicultural community (21 percent higher) and a much less important role for the Department in dealing with the issue of homelessness (24 percent less than the community).

d) Additions and Deletions to the List of Challenges

On the whole, there were relatively few additions and even fewer deletions suggested. The majority of respondents had neither additions or deletions.

The community's suggested additions to the list of challenges to Toronto's health emphasized the lack of community mental health services, the need to address recycling and waste disposal, problems posed by the waterfront (Harbourfront?) and downtown highrises, the need for more leisure, recreation and fitness programming, the need for an expanded role for allied health professionals and alternative health services, the need for expanded health education programs in the schools, the need for better transit and bicycle safety, more parks, and a variety of other topics.

The Department staff had few items to add to the list, most notably issues relating to occupational health and the workplace environment, the housing shortage and services for the elderly and others in need in the community.

Very few suggestions for deletion from the list were made by the Department. Similarly, the community only included a few items to be deleted from the list of challenges. The most frequently mentioned one was nuclear war, but this was suggested by only 11 people out of the 211 responding from the community, and three out of 59 Department respondents. Multicultural issues, community violence and fewer youth were rejected by five, five, and four persons respectively. The only item on the list which was not rejected by anyone was homelessness. Common reasons for rejection were:

A. not affecting health

B. other department's responsibility

3. How Do We Make Toronto More Healthy?

The responses to the questions as to what people would do to make Toronto a more healthy city: a) if they were on City Council; or b) personally or through their organization were categorized in the same way as before, based on the elements of the vision. While less than perfect, the categorization does convey the sense of what people felt should be done. Again as before, we present the results in terms of the largest categories, for both community and Department staff, for each of the two questions.

It is interesting to compare the community's views on what City Council should do with their description of a healthy community and of the challenges to health. Again, environmental protection and the provision of housing received the major emphasis.

However, while safety was seen as an important component of a healthy city, violence and nuclear war only ranked eighth and tenth in terms of their challenge to health, (though both were cited as important or very important challenges by over half the respondents); when it came to priorities for City Council action, safety was barely mentioned, with only six of more than 200 respondents mentioning it. On the other hand, health education/promotion/protection received more emphasis, as did the provision of community services, while so many people mentioned recycling and good waste management that it received a category all on its own.

The community members placed strong emphasis on simple and straightforward personal actions with voluntary group/community action and lobbying tactics. In most categories, all three strategies were mentioned, with personal action usually being predominant: people are willing to pick up litter, recycle their garbage, walk and cycle more, be involved in their community and in local politics, lobby, speak out and take action, and above all, to keep themselves healthy. On the other hand, while they clearly see housing as a priority, they recognize that there is little they can do personally except advocate.

The responses of the Department staff showed some interesting differences from those of the community. While housing was identified in particular, and while pollution control, health and social services, and better transportation were also priorities, the personal actions were very different. The emphasis was very much on what could be done by the Department and City government, with little emphasis on personal action. While this presumably reflects the question, which asked "What could you personally or your organization do?", the lack of attention to personal action is noteworthy. However, as with the community, the main response was to keep personally healthy and to help others to do the same. There was no mention of such topics as picking up litter, recycling garbage, walking, cycling and other personal actions that would address environmental and transportation problems.

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Appendix III

Bibliography

Listed here are the major sources for the information we have presented, section by section. Much of the data was taken from *Environmental Scan, 1987*, a background report on the major challenges to health identified by the Subcommittee and prepared by Department of Public Health staff. A copy of the report is held in the Resource Centre, Department of Public Health, 180 Dundas Street West, Suite #1303.

General

City of Toronto Department of Public Health. *Community Health Survey, 1983*. Toronto, 1984.

City of Toronto Department of Public Health. *Health Status Report, 1983*. Toronto, 1985.

City of Toronto Department of Public Health. *Healthy Toronto 2000: A Discussion Paper*. Toronto, 1985.

Hancock, T. and Duhl, L. *The Healthy City: Promoting Health in the Urban Context*. Copenhagen: WHO Europe, 1986.

Health & Welfare Canada. *A New Perspective on the Health of Canadians*. (Lalonde Report) Ottawa, 1974.

Health and Welfare Canada. *Achieving Health For All: A Framework For Health Promotion*. Ottawa, 1986.

Government of Ontario. Ontario Health Review Panel. *Toward a Shared Direction for Health in Ontario*. (Evans Report) Toronto, 1987.

Government of Ontario. Panel on Health Goals for Ontario. *Health for All Ontario*. (Spasoff Report) Toronto, 1987.

Government of Ontario. Minister's Advisory Group on Health Promotion. *Health Promotion Matters in Ontario*. (Podborski Report) Toronto, 1987.

World Health Organization Europe. *Targets For Health For All*. Copenhagen, 1985.

World Health Organization Europe. *Ottawa Charter for Health Promotion*. Copenhagen, 1986.

Background Documents and Commissioned Reports

Presentations to Healthy Toronto 2000 Subcommittee

Frank, J. Department of Preventive Medicine and Biostatistics, University of Toronto. HT 2000 Subcommittee, October 2, 1986.

Berlin, S. Planner. HT 2000 Subcommittee, October 15, 1986.

Perkins, F. Personal Health Services Manager, Department of Public Health, City of Toronto. HT 2000 Subcommittee, October 15, 1986.

Clutterbuck, P. Associate Program Director, Canadian Mental Health Association. HT 2000 Subcommittee, January 28, 1988.

Novick, M. Dean, Faculty of Community Services, Ryerson Polytechnical Institute. HT 2000 Subcommittee, January 28, 1987.

Macpherson, A.S. Medical Officer of Health, City of Toronto. HT 2000 Subcommittee, October 29, 1986.

Rachlis, M. McMaster University. HT 2000 Subcommittee, October 29, 1986.

School Health Policy Group, Department of Public Health, City of Toronto. HT 2000 Subcommittee, November 5, 1986.

Adult & Seniors Policy Group, Department of Public Health, City of Toronto. HT 2000 Subcommittee, November 5, 1986.

Social Environment & Mental Health Policy Group, Department of Public Health, City of Toronto. HT 2000 Subcommittee, November 10, 1986.

Physical Environment Risk Reduction Policy Group, Department of Public Health, City of Toronto. HT 2000 Subcommittee, November 10, 1986.

Parent & Child Health Policy Group, Department of Public Health, City of Toronto. HT 2000 Subcommittee, December 2, 1986.

Lifestyle Risk Reduction Policy Group, Department of Public Health, City of Toronto. HT 2000 Subcommittee, December 2, 1986.

City of Toronto Department of Public Health. *Review of Implementation of Recommendations in "Public Health in the 1980's"*. Toronto 1986.

City of Toronto, Toronto Department of Public Health. *Environmental Scan '87*. Toronto, 1987.

City of Toronto Department of Public Health. *An Analysis of Responses to the Healthy Toronto 2000 Questionnaire*. 1988.

City of Toronto Department of Public Health, Information Section. Special Tabulations:

- Standardized Mortality Rates for Major Causes of Death, 1976 & 1986.
- Accidental Deaths by Cause, Site and Age, 1983-1986.
- Analysis of Toronto Community Health Survey By Income, 1983.
- Cancer and Heart Disease Deaths, 1976 - 1986.

The Context

Bator, P. A. *Saving Lives on the Wholesale Plan: Public Health Reform in the City of Toronto, 1900-1930*. Ph.D. Thesis, University of Toronto, 1979.

Bator, P. A. "The Struggle to Raise the Lower Classes: Public Health Reform and the Problem of Poverty, Toronto 1910-1921." *Journal of Canadian Studies* 14, 1 (1979) 43-49.

Ontario Community Development Association. *Brief to Ontario Liberal Party*. Toronto, 1986.

Severs, A. "Public Health as a Catalyst to the Growth of Municipal Departments in Early Toronto". *Canadian Journal of Public Health* (Accepted for publication) 1988.

Statistics Canada. Business, Provincial and Municipal Relations Division. *Toronto 150: Portrait of a Changing City*. Ottawa, 1984.

Yorke K. M. "Saving Lives on the Wholesale Plan". *Macleans Magazine* 28, 12 (1915) 20-23.

World Health Organization Europe. *Health Promotion Glossary*. Copenhagen, 1986.

The Changing City

The Community's Composition

City of Toronto Planning and Development Department. The Toronto Region: Population Trends and Projections. *Research Bulletin No. 25*. Toronto, 1985.

City of Toronto Planning and Development Department. *Toronto Construction Trends*. Toronto, 1987.

An Aging Population

Marshall, V. (Ed) *Aging in Canada: Social Perspectives*. Don Mills: Fitzhenry and Whiteside, Ltd., 1987.

Chappell, N.L., Strain, L.A., and Blandford, A. *Aging and Health Care: A Social Perspective*. Holt, Rinehart and Winston of Canada, Toronto, 1986.

Gross, M.J., and Schwenger, C.W. *Health Care Costs For the Elderly in Ontario: 1976-2026*. Ontario Economic Council, Toronto, 1981.

Priest, G. E. "The Older Old in Canada: How do they live?" Presented to the Annual Meeting, Canadian Population Society, Windsor, 1988.

Selby, P., and Schechter, M. *Aging 2000: A Challenge For Society*. London: MTP Press Ltd., 1982.

Simmon-Tropea, D.; Osborne R.; and Schwenger, C. *Health Status and Health Services For Elderly Canadians*. Research Paper No. 8. Program in Gerontology, University of Toronto, 1986.

Spielberg, L.A. *Planning For the Third Age: Selected Demographic and Health Characteristics of Toronto Residents Aged 65 and Over*. Toronto: Department of Public Health, 1986.

Statistics Canada. *The Elderly In Canada*. Ottawa, 1984.

Statistics Canada. *Canada's Changing Population Distribution*. Ottawa, 1984.

A Multicultural Community

Annual Report to Parliament on Future Immigration Levels. Ottawa, 1986.

Ashawasega, A. E. *Presentation to Healthy Toronto 2000 Subcommittee*. Anishnawbe Health. Toronto: 1988.

Ontario Ministry of Citizenship and Culture. *Immigrant Landings to Ontario January - December 31, 1984*. Toronto, 1986.

Ontario Ministry of Citizenship and Culture. *Immigrant Landings to Ontario January 1 to December 31, 1986*. Toronto, 1986.

Statistics Canada. *1984 Census of Canada*. Ottawa, 1981.

Statistics Canada. *Canada's Immigrants, 1984*. Ottawa, 1984.

Changing Family Structures

Statistics Canada. Housing, Family and Social Statistics Division. *Lone Parenthood, Characteristics and Determinants - Results from the 1984 Family History Survey* by I. Pool and M. Moor. Ottawa, 1984.

Statistics Canada. Housing, Family and Social Statistics Division. *Family History Survey: Preliminary Findings* by T.K. Burch. Ottawa, 1985.

Statistics Canada. Housing, Family and Social Statistics Division. *Union Formation and Dissolution: Results of the 1984 Family History Survey* by T. Burch and A. Madan. Ottawa, 1986.

Waigon, S. "Canada's Families in the 1980's: Crisis or Challenge?" *Transition*, 17 (1) 1987.

The Community's Social Condition

Housing

City of Toronto Department of Public Health. *Housing and Health: Public Health Implications of the Affordable Housing Crisis*. Toronto, 1984.

City of Toronto Housing Policy Review Committee. *Living Room II: A City Housing Policy Review*. Toronto, 1986.

City of Toronto Department of Planning and Development. *Extension of Rental Housing Protection Act, 1986*. (Report to Housing Action Committee) Toronto, 1988.

Metropolitan Toronto Community Services Department. *Statistics Re: Cases Involving Dependent Children January 1 - December 31, 1986*. Toronto, 1987.

Metropolitan Toronto Community Services Department. Hostel Operations Unit. *Admissions to Shelter System January 1 - December 31, 1986*. Toronto, 1987.

Metro Toronto District Health Council. *Housing and the Health of the Elderly*. Toronto, 1988.

Mitchell, A. "Homeless Youth: Little Shelter from the Storm." *The Toronto Star*. July 8, 1988.

Government of Ontario. Ontario Social Assistance Review Committee. *Transitions*. (Thomson Commission Report) Toronto, 1988.

Government of Ontario. Ontario Ministry of Housing. *More Than Just a Roof: Action to End Homelessness in Ontario - Final Report of the Ministry's Advisory Committee on the International Year of Shelter for the Homeless*. Toronto, 1988.

Statistics Canada. "Dwellings and Households" 1986 Census, pp 93-104. Ottawa, 1988.

Food

Bright-See, E. "Diet and Prevention of Cancer: The State of Knowledge and Current Dietary Recommendations." *Journal of the Canadian Dietetic Association* 48, 1 (1987) 13-20.

Campbell, C.; Katamay, S.W.; Oram, B.J.; and Berchem, P.A. "Hunger, Poverty and Malnutrition: The Nutritional Implications of Food Insecurity in Canada." Presented at the National Conference on Hunger. Toronto, 1986.

Cole-Hamilton, I. and Lang, T. *Tightening Belts: A Report on the Impact of Poverty on Food*. London Food Commission. London, 1986.

Daily Bread Food Bank. *Who is Hungry?: A Preliminary Report About the Circumstances of Persons Receiving Emergency Food Assistance in the Metro Toronto Area*. Daily Bread Food Bank. Toronto, 1987.

Haughton, B., "Developing Local Food Policies: One City's Experience." *Journal of Public Health Policy* 8, 2 (1987) 180-191.

Petrey, D. L. "Knoxville's Food Policy Council: A Case Study". Presented at 2nd International Conference on Health Promotion, Adelaide, South Australia. 1988.

Statistics Canada. *Consumer Price Index*. (Personal Communication) Ottawa, June 1988.

Work

Canadian Mental Health Association. *Work and Well-Being: The Changing Realities of Employment*. Toronto, 1984.

Canadian Council on Social Development. *Social Development Overview* 4(2). Ottawa, 1987.

City of Toronto Department of Public Health. *Equal Opportunity Action Progress Report: Career Pathing and Succession Planning and Service Delivery to the Community*. Toronto, 1986.

City of Toronto Planning and Development Department. *Youth and Seniors Unemployment*. (Personal Communication) July, 1988.

Labonte, R. *Unemployment in Canada*. Ottawa: Caduceus Publications, 1985.

Government of Ontario. Ontario Social Assistance Review Committee. *Transitions*. (Thomson Commission Report) Toronto, 1988.

Government of Ontario. Ontario Women's Directorate. *Women in the Labour Force, Basic Facts: Factsheet No. 2*. Toronto, 1986.

Government of Ontario. Ontario Women's Directorate. *Women in the Labour Force, Child Care: Factsheet No. 4*. Toronto, 1986.

Education

Queen's University. Social Program Evaluation Group. *Canada Health Knowledge Survey: 9, 12 and 15 Year Olds*. Kingston, 1982-83.

Ontario Ministry of Education. Statistical Information. Toronto, 1987.

Ontario Ministry of Education. *Ontario Elementary and Secondary School Enrolment Projection 1986 - 1995; Preliminary Report*. Toronto, 1986.

Statistics Canada. *Schooling in Canada: 1981 Census of Canada*. Ottawa, 1984.

Income Distribution

City of Toronto Planning and Development Department. *Toronto Region Incomes Research Bulletin 24*. Toronto, 1984.

Metropolitan Toronto Planning Department. *Projections: Population, Labour Force, Household and Housing*. Toronto, 1984.

Metropolitan Toronto Planning Department. *The Changing Metropolitan Economy*. Toronto, 1986.

Metropolitan Toronto Community Services Department. *Adequacy of General Welfare Assistance*. Toronto, 1986.

National Council of Welfare. *Progress Against Poverty*. Ottawa, 1986.

National Council of Welfare. *Poverty Lines*. Ottawa, 1986.

Government of Ontario. Ontario Social Assistance Review Committee. *Transitions*. (Thomson Commission Report) Toronto, 1988.

Social Planning Council of Metropolitan Toronto. *A Social Report for Metropolitan Toronto, No. 1*. Toronto, 1985.

Statistics Canada. *Changes In Income In Canada: 1970-1980*. Ottawa, 1984.

Safety, Security and Peace

City of Toronto Information Brochure. "You Decide - What One Nuclear Bomb Would Do To Toronto." Toronto, 1982.

City of Toronto Mayor's Committee on Aging. *Elder Abuse: A Shared Problem*. Toronto, 1984.

Ontario Advisory Council on Senior Citizens. *A Report on Elder Abuse*. Toronto, 1986.

Bouchard, C. "Poverty: A Dangerous Curve". *Transition* 18, 3 (1988) 9-11.

Couchman, R. "Wife Assault in Canada: Concern is Not Enough." *Transition* 18, 3 (1988) 4-6.

Finn, P. and McNeil, T. *The Response of the Criminal Justice System to Bias Crime: An Exploratory Review*. Submitted to the National Institute of Justice - U.S. Department of Justice. Cambridge, Mass. ABT Associates Inc., 1987.

MacLeod, L. "A Changing Vision of Wife Battering." *Transition* 18, 3 (1988) 6-8.

Self, J. "Bowers V. Hardwick: A Study of Aggression." *Human Rights Quarterly* 10 (1988) 395-432.

The Environment of the City

City of Toronto Department of Public Health. *Toronto: State of the Environment*. Toronto, 1988.

City of Toronto Department of Public Health. *Toronto's Drinking Water: A Chemical Assessment*. Toronto, 1984.

City of Toronto Department of Public Health. *Human Exposure Routes to Selected Persistent Toxic Chemicals in the Great Lakes Basin: A Case Study of Toronto and Southern Ontario Region*. Toronto, 1986.

City of Toronto Department of Public Health. *Establishment of an Environmental Protection Office*. Toronto, 1987.

Coleman, Alice. *Utopia on Trial*. London, H. Shipman, 1985.

Davies, K. "Concentrations and Dietary Intake of Selected Organochlorines including PCBs, PCDDs and PCDFs in Fresh Food Composites Grown in Ontario, Canada." *Chemosphere*, 17, 2 (1988) 263-76.

Environment Canada. *Report of the National Task Force on Environment and Economy*. Ottawa, 1987.

Metropolitan Toronto Planning Department. *Central Area Monitoring Program Second Annual Report*. Toronto: Metropolitan Toronto Planning Department, 1988.

Ontario Ministry of the Environment. *Air Quality Index (AQI) Statistics City of Toronto and Surrounding Areas Period June - August 1988*. Toronto, 1988.

Ontario Ministry of Health. *Report of the Committee on Environmental Hypersensitivity*. Toronto, 1985.

Report of the World Commission on Environment and Development. *Our Common Future*. (Brundtland Report). Oxford University Press, 1987.

The Community's Health

Inequalities in Health

Ashawasega, A. E. President, Anishnawbe Health Toronto. *Submission to Healthy Toronto 2000 Subcommittee*. Toronto, 1988.

Ontario Medical Association. *Submission to the Ontario Social Assistance Review Committee*. Toronto, 1987.

Townsend, P. and Davidson, N. *Inequalities in Health: The Black Report*. Harmondsworth: Penguin, 1982.

Whitehead, Margaret. *The Health Divide: Inequalities in Health in the 1980's*. London: Health Education Authority, 1987.

Wilkins, Russell and Owen, Adams. *The Healthfulness of Life*. Montreal: Institute for Research in Public Policy, 1983.

Cancer

Canadian Cancer Society. *Canadian Cancer Statistics*. Toronto, 1988.

Substance Use and Abuse

Jaffe, J. "Drug Addiction and Drug Abuse" in *The Pharmacological Basis of Therapeutics*. L. Goodman and A. Gilman (Eds.) New York: Macmillan, 1980.

Smart, R. E., and Adlaf, E. M. *Alcohol and Other Drug Use Among Ontario Students in 1987, and Trends Since 1977*. Toronto: Addiction Research Foundation, 1987.

Smart, R. E., and Adlaf, E. M. *Alcohol and Other Drug Use Among Ontario Adults 1977 - 1987*. Toronto: Addiction Research Foundation, 1987.

Vingilis, E., Liban, C., McLellan, B., McMurtry, R. Blood, "Alcohol Concentrations Among Motor Vehicle Accident Admissions To a Regional Trauma Unit." *Canadian Journal of Public Health* (In press.)

Mental Health Problems

Health and Welfare Canada. *Mental Health for Canadians: Striking A Balance*. Ottawa, 1988.

Trauma

Metropolitan Toronto Police *Annual Statistical Report - 1987*. Toronto, 1987.

Ontario Ministry of Transportation and Communications. *1986 Annual Statistics*. Toronto, 1987.

Ontario Ministry of Transportation and Communications. *Ontario Road Safety Annual Report, 1986*. Toronto, 1986.

Vingilis, E., Liban, C., McLellan, B., McMurtry, R. Blood, "Alcohol Concentrations Among Motor Vehicle Accident Admissions To a Regional Trauma Unit." *Canadian Journal of Public Health* (Accepted for publication, 1988.)

The Community's Health Care System

Canadian Medical Association. *Health: A Need for Redirection*. Ottawa, 1984.

Metropolitan Toronto District Health Council. *Organization Review of the Metropolitan Toronto District Health Council*. Toronto, 1988.

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